INTERIM ARBITRATION AWARD (PHASE I)

I. Introduction

As prescribed by law, the health care system known as Medicare has become a defining feature of Canadian nationhood. It is also a reasonable expectation of our people that adequate health care will be available to them when it is needed. Government and the physicians of the province have crucial roles to play in this important endeavour. As will be seen, this critical relationship has been deteriorating for at least the last ten years in this province, and that trend must be reversed.

To this end, the B.C. Medical Association ("BCMA"), representing all British Columbia physicians, and the Government of British Columbia ("the Government"), are engaged in the negotiation of new agreements to determine compensation and other matters that are fundamental to the provision of proper and appropriate medical services to the public.

It is not our role to assign blame for these difficulties, but some explanation is necessary. It is clear that the Government has responsibility for the proper expenditure of public money, which amounts to almost $10 billion for health care each year. Of that amount $1.9 billion is paid to the approximately 8,000 physicians of the province. The balance is for nurses and other support staff, hospitals, pharmaceuticals, other programs and administration.

Government also has responsibility, as clearly stated in legislation I shall describe below, to ensure both the preservation of Medicare and reasonable compensation for physicians. Government has on occasion used the enormous power it has, including the arbitrary, statutory cancellation of a negotiated physicians' pension plan and other threats to use legislation to get its way and physicians on occasion have exerted their powerful influence on the public by engaging in partial withdrawals of services. The physicians of the province have understandably resisted any risks to the independence of their profession or the erosion of their compensation.

Basically, there is a balance and counterbalance in this relationship. The Government controls the money and decides policy, but most physicians are independent practitioners who are paid on a Fee for Service (FFS) basis for whatever services they provide as described in a Fee Schedule. They are not obliged to work under unacceptable professional or other conditions. Like other citizens, they are entitled not to work, or even to leave the province to practice elsewhere. This kind of stand-off played itself out in the 1990s when the Government chose to exercise its contractual right to pro-ration (reduce) fees on a percentage basis when it believed the Government allocated budget might not be sufficient to pay anticipated fee claims during the fiscal period. The doctors regarded this as a subsidy they were expected to furnish in order to sustain medical services that they and the law regard as the responsibility of Government. The physicians responded to pro-rationing with Reduced Activity Days (RAD) when most of them refused to provide services (except emergencies) to keep total charges within the budget and to maintain the integrity of their fee schedule. For example, there were 20 RAD days 1998 - 99.

I pause to say I believe the quality of medical services provided by the physicians of the province to the public is superb once a patient gets to see a doctor, but waiting periods for some elective, non-emergency and many other services are far too long. This is caused in large measure by a lack of physicians, nurses, support staff and other facilities, particularly hospital beds and operating theatres. Physicians, of course, take years to train and over 100,000 of our citizens do not have a family doctor because of a shortage of doctors and because many general practitioners cannot take on new patients. Physicians without access to necessary hospital facilities cannot earn the fees necessary to keep them here.

There is a serious risk that dissatisfied physicians might leave the province as there is a worldwide demand for their services. This reality has been recognized by informed officials outside these Arbitration proceedings. For example, a Select Standing Committee of the Legislature on Health recently reported:

> Almost every type of doctor is in short supply in B.C.: family doctors, surgeons, pathologists, oncologists and other specialists. An estimated 100,000 people in B.C. do not have a family doctor; two-thirds of GPs and family doctors in Canada

> are not taking any new patients; and the province needs approximately 350 new physicians to replace those who are retiring, moving away or leaving their practice – more than double the number our medical school is able to train. In fact, the committee was told that Canada is the only country in the Organization for Economic Co-Operation and Development (OEDC) that has never trained enough doctors to meet its needs.

Quite recently, the Government of Alberta, facing more or less the same problems, concluded a generous compensation settlement with its physicians that provides compensation considerably in excess of that payable to the physicians in this province. I will have much more to say later in this award about competition for physicians and their compensation.

Most agencies and individuals responsible for Canada's health system think the delivery of medical services could be improved. I suppose this will always be the case. There are provisions in the past and present Master Agreements for joint study and action by Government and doctors, but this process has not often been initiated by Government.

I have no doubt that Government has the right, and the

obligation, to take such steps as may be thought necessary to initiate necessary and reasonable changes to the delivery of medical services. For example, the Ministry of Health and some physicians have the view that some medical services might best be delivered by physicians operating in groups or under various kinds of contract for services. The BCMA does not oppose physicians entering into voluntary contracts for services. Unfortunately, the present adversarial climate, as shown by some of the positions taken in these proceedings, is not likely to produce the kind of results that might be in the public interest. Mutual mistrust and lack of confidence have been the rule for upwards of ten years. It is essential that a new, improved relationship be established.

Fortunately, and possibly in recognition of the fact that mutual mistrust and lack of confidence had been the rule for so long, the parties entered into a new negotiating strategy in February, 2000 that led to this mediation-arbitration proceeding. Many physicians expect this process to mark a new beginning for a better relationship with Government.

2. The Contractual Arrangements

Although there was a Master Agreement in force expiring March 31, 2001, the Government and the BCMA in February, 2000 entered into a "Framework Memorandum" that provides the basis for these proceedings.

This Framework Memorandum extended the Master Agreement to March 31, 2001, and provided that the parties would seek to reach a new "Working Agreement" commencing April 1, 2001 that would address the issues of compensation, reserve accounts, on-call issues, physician benefit plans and any other issues which the parties agree to negotiate at the Working Agreement Negotiations.

Timelines for these negotiations were stated. It was agreed that negotiations would commence not later than October 1, 2001 to be effective April 1, 2001. The Framework Memorandum also provided for the possible use of a conciliator, a fee increase of 2% effective September, 2000, payment by Government of 100% of CMPA premiums, provisions for four subsidiary agreements

(Sessional, Salary, Service, and Rural), and a "conceptual framework" for negotiations. It was also agreed that BCMA would not sponsor, support or condone withdrawals of service during the term of the extended Master Agreement.

Various clauses 4.2.4 of the Framework Memorandum, which provides the jurisdiction for this arbitration provide:

> 4.2.4 If, by March 31, 2001, the parties have not reached an agreement on the outstanding issues, a three person arbitration board will be established to mediate between the parties and if no agreement is reached to hold a hearing and to issue a final and binding award on the outstanding issues. The government and the BCMA will each appoint one member to the arbitration board and the third member will be appointed by their mutual agreement. If such agreement is not achieved either party may apply to the Chief Justice of the Supreme Court of British Columbia to make the appointment. The third appointee will act as the chair of the arbitration board. <u>The terms of Reference of such an arbitration will include the objective of being consistent with the law and the terms of the Master Agreement, reflecting the financial circumstances of government, the need to provide reasonable compensation to the physicians for the services rendered, and the operational and medical resource needs of the Health Authorities. (emphasis added)</u>
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> 4.2.7 The government and the BCMA will share equally the costs of the arbitration board and will each be responsible for the costs of their own nominees to the arbitration board. The government and the BCMA will each be responsible for their own costs for participating in the arbitration.

4.2.8. Unless otherwise agreed to by the parties, all future Working Agreement negotiations will be subject to the same dispute resolution mechanism as the April 1, 2001 Working Agreement.

4.2.9 The Working Agreement will include four (4) subsidiary agreements, as follows:

- Sessional Agreement
- Salary Agreement
- Service Contract Agreement
- Rural Agreement

These four (4) subsidiary agreements will describe the terms and conditions, including the range of payment rates and benefits, which are uniquely applicable to physicians providing services under each of these payment modalities. They will also provide the key elements that are necessary in contracts between the practitioner(s) and the contracting body for the services. Except as specifically varied by a term of the Working, Sessional, Service Contract, Salary or Rural Agreements, all terms of the Working Agreement will apply to physicians providing services under any of these contracts. In the future the negotiation of the Sessional, Salary, Service contract and Rural Agreements will occur in tandem with the negotiation of the Working Agreement(s) and will be subject to the same dispute resolution mechanism as Working Agreement negotiations except that, prior to the implementation of the dispute resolution procedures, the parties shall refer the unresolved issue(s) back to the working Agreement negotiating committees who will attempt a resolution of the disagreement(s).

The parties entered into a “Second Master Agreement” dated Feb. 28, 2001 that contemplated a negotiated general settlement of

all outstanding issues. It will expire at midnight, March 31, 2006. Of particular interest are the following:

> 2.1 This Agreement applies to those physicians resident within the Province whose services are compensated by funds provided by the Government either directly or through other public agencies.

Article 12.3.1 to 3 reflect the Government's concern about withdrawals of service. They provide that the Government will not exercise its power to pro-rate without 12 months notice, and that the BCMA will not sponsor, encourage or condone withdrawals of service by physicians so long as prorating was not in effect. Article 12.8 provided:

> It is acknowledged that certain difficulties have arisen due to the concern of physicians that they have not been provided with suitable support, working conditions or access to public facilities. When such concerns arise the Government and the BCMA will form task forces to work together to attempt to relieve such concerns. Such task forces will be jointly chaired by a representative of the government and a representative of the BCMA and will issue a report to the parties within thirty days of their appointment.

No such task forces were established.

We were advised negotiations did not commence until the late Spring of 2001. The parties were unable to reach a new agreement through negotiations so they turned to mediation and arbitration.

3. Mediation-Arbitration

In July, 2001, the parties appointed me the third member (Chair of the arbitration board), and sole mediator. Dr. Charles Wright was appointed to the Board by the Government and Dr. William Orovan was appointed by the BCMA.

Pursuant to the mediation component of this arrangement, I started meeting with the parties on July 30, 2001 with a view to reaching a mediated settlement. At that first meeting, the BCMA tabled its physicians' compensation proposal for parity with Alberta physicians which proposed a required fee increases of 29.3% for General practitioners and an average of 35.2% for medical specialists. (These were later revised to 28.9% and 34.7 respectively). Actual percentage adjustments were identified for 19 categories of specialists ranging from a high of 66.6% and a low of 13.3%. The Government made no compensation proposal during mediation and its position at arbitration was BC doctors are already paid more than Alberta doctors, but it agreed to pay an additional $115 million annually, including $61.9 million already spent in the

current fiscal period and the balance for various programs. The Government proposed no general fee increase for the term of the new Working Agreement.

The parties, however, attempted to reach agreement on the terms of the subsidiary agreements, for which separate negotiation tables were established. The mediation schedule contemplated that “Main Table negotiations”, including compensation, would be resumed in early November.

Considerable progress was made in discussions about the subsidiary agreements except those provisions impacted by the compensation question and the terms of service contracts. Because of the impasse resulting from the absence of a proposal from Government regarding compensation, the parties agreed to proceed with arbitration on certain questions that they designated as the “Arbitration, Phase I”. The parties agreed that the Board retains jurisdiction to deal with any problems that are not resolved by our Award on Phase I.

We commenced our arbitration hearing at a brief meeting on November 14, 2001 when the parties submitted the following "Phase I" questions for our decision:

3.0 Phase One Arbitration Questions

A. Compensation

i) What methodology, consistent with the terms of reference, should be used to determine "reasonable compensation" for British Columbia physicians?

ii) In the event it is necessary to compare the compensation of physicians in one jurisdiction to that of another, what model should be used for that comparison?

iii) Based upon the terms of reference and the answers to i)and ii), what adjustments, if any, should be made to total compensation for B.C. physicians? What percentage change, if any, should be applied to the compensation of general practitioners in B.C.? Of specialists in B.C.? What should be the rates of compensation for salary, service and sessional contracts?

iv) Should physicians receive compensation for providing telephone advice to patients? For providing prescription renewals by telephone?

v) If either of the answers to iv) is "yes", what should be the value of such compensation?

vi) Should physicians receive compensation for completing forms that are required by the Government or other public agencies?

vii) If the answer to vi) is "yes", what should be the value of such compensation?

viii) Should physicians receive compensation for the time spent performing non-clinical work, such as serving on committees and boards which are required by Medical Staff By-laws?

ix) If the answer to viii) is “yes”, what should be the value of such compensation?

B. Payment for On Call/Availability/Doctor of the Day

i) To which B.C. physicians should on call/availability Payments be made available?

ii) How should on-call/availability payments be Structured? Should on call/availability compensation be in the form of an hourly payment or a “lump sum”?

iii) What should be the value of on-call/availability payments?

iv) Should there be different levels of payment for on call/availability between:

- Physicians covered by the Rural Subsidiary Agreement and other physicians?
- Different specialties?
- Specialists and general practitioners?

v) Should there be payment for on call/availability in circumstances where less than 24 hours/ 7 days a week/ 52 weeks per year coverage is provided by a physician or group of physicians?

vi) Should physicians be compensated for providing “Doctor of the Day” coverage to a hospital?

vii) If the answer to vi) is “yes”, what should be the value of that compensation?

C. Administrative Contracts

i) Should physicians be required to sign binding Individual service contracts in order to receive the

benefits under the Working or subsidiary agreements?

ii) Should there be some other method by which Physicians should be prevented from withdrawing services? If so, what should that method be?

D. Scope of Service, Sessional and Salary Agreements?

1)Which group of physicians are covered by the Provincial Service, Salary and Sessional Agreements?

E. Term of the Agreement

1) What should be the term of the Working Agreement and subsidiary agreements?

I should mention that the BCMA Brief on compensation includes some matters not specifically mentioned in the foregoing questions submitted for the decision of the Board. Mr. Harris informed us prior to December 3, 2001 that the Government did not object to having these further matters considered by the Board so that the entire compensation issue would be before the Board.

After these questions were submitted, the arbitration adjourned to December 3, 2001 on the understanding that each party would furnish comprehensive written briefs. These voluminous submissions were duly received including the Government's first

compensation proposal. It was that there should be no general fee increase but that $115 million of new funding would be allocated to benefits, Alternative Payment Plans, rural recruiting and retention and some on-call payments. Needless to say, this disappointed the physicians greatly.

The arbitration hearings resumed on December 3, and continued until December 12 when the evidence was completed. The BCMA case was largely devoted to comparisons with Alberta compensation and personal accounts by British Columbia physicians about the present state of medical practice in this province. The Government's case stressed the financial circumstances of the province, the difficulties of service withdrawals, and a contradicting theoretical compensation comparison with Alberta. At the conclusion of the evidence, each party filed responsive replies to the earlier comprehensive briefs.

It is a credit to the parties and their counsel, to whom we are much indebted, that they were able to present their evidence on such a complicated, multi-faceted matter with such professional skill and efficiency. The respective positions could not have been more ably presented.

We then heard counsels' arguments on January 14 and 15, 2002 and Phase I was left to us for decision. Unfortunately, as I shall endeavour to explain in a moment, I do not find it possible to give a comprehensive decision at this time but I earnestly hope that what I am about to say will assist the parties to reach a general solution. If they are unable to do so, the Board will struggle further with these vexing problems.

4. The Statutory and Factual Background

4.1. *The statutory provisions*

The starting point for any discussion of medical economics must be the Canada Health Act, R.S.C. 1985, c. C-6, which provides

federal financial assistance to provinces that satisfy the criteria described in sections 7 to 12 of that Act. Sections 7, and 12(1)(c) Provide:

> 7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:
>
> (a) public administration;
> (b) comprehensiveness;
> (c) universality;
> (d) portability; and
> (e) accessibility.
>
> 12.(1) In order to satisfy the criterion respecting accessibility, the health care insurance of a province…
>
> (c) must provide for <u>reasonable compensation</u> for all insured health services rendered by medical practitioners or dentists; …(emphasis added)

Following Canada's lead, the province enacted companion legislation, the latest version being the *Medicare Protection Act* R.S.B.C. 1996 c. 286, particularly Part 9 – General Provisions, and s. 5. The former, the Preamble to the Act, provides:

> <u>WHEREAS the people and government of British Columbia believe that Medicare is one of the defining features of</u>

> Canadian nationhood and are committed to its preservation for future generations. (emphasis added)
>
> WHEREAS the people and government of British Columbia wish to confirm and entrench universality, comprehensiveness, accessibility, portability and public administration as the guiding principles of the health care system of British Columbia and are committed to the preservation of these principles in perpetuity;
>
> WHEREAS the people and government of British Columbia recognize a responsibility for the judicious use of medical services in order to maintain a fiscally sustainable health care system for future generations;
>
> AND WHEREAS the people and government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay.

S. 5(1) (a) to (u) of the Act describes the powers of the B.C. Medical Commission in very broad and comprehensive terms. The Medical Services Commission is responsible for the administration of the Medical Services Plan. Subs. 2 provides:

> (2) The commission must not act under subs. (1) in a manner that does not satisfy the criteria described in section 7 of the Canada Health Act (Canada).

Both the First and Second Master Agreements provide in Preambles that, “The parties wish to enter into a[n] … agreement for the purpose of continuing an ongoing relationship as provided for in this Agreement”, and:

> C. THE parties wish to work as partners in the health care system to achieve certain objectives, including the following:
>
> 1. To maintain and enhance the principles of Medicare;
> 2. To ensure a stable long term relationship between the Government and the BCMA;
> 3. To ensure and enhance the delivery of medically required services to residents of the Province in an efficient, high quality and effective manner;
> 4. To ensure that physicians are appropriately compensated for providing services covered by the Medical Services Plan, or under other alternative payment arrangements;
> 5. To ensure that the medical care system will continue to function well;
> 6. To contribute to the achievement of a mix and distribution of physicians based upon British Columbia’s needs.

Thus, under the applicable legislation, the Master Agreements and the Framework Memorandum under which we derive our jurisdiction, we are required to determine “reasonable compensation” for physicians in the province. That question, however, cannot be determined in isolation from the other statutory provisions such as the *Medical Protection Act* and the Framework Memorandum, including

consistency with the law and the Master Agreement, the financial circumstances of government (not of the province) and the operational and medical resource needs of the Health Authorities.

4.2. *The present circumstances*

It is regrettable that while the mediation and arbitration proceedings were carried out with the utmost civility, relations between the majority of the members of the medical profession and the Government could not be much worse than they are. No one can say when the deterioration began, but the unilateral cancellation by the Government of a previously negotiated pension plan in the early 1990's and the Government initiation of pro-rationing as well as chronic shortages of facilities certainly did not help. The BCMA, which is a voluntary organization recognized by the Government as the sole bargaining authority for all the practicing physicians in the province, has described the 1990's as a "decade of disaster". In its submission, the BCMA quoted a former President of the BCMA as saying that the previous government "broke the social contract between doctors and the government and the result is a relationship

that is dysfunctional." In Sec. VII of its written submission, the Government recognized this reality but placed the source of the difficulty on a much narrower basis. It states, at p. 73:

> 7.2 The past several years have witnessed several service withdrawals by physicians to pressure Government and health authorities for additional remuneration. General discontent and dissatisfaction among physicians and public alike has increased the struggle of health authorities to provide continuous services.
>
> 7.3 For physicians, much of this discontent revolves around inequities in service contract arrangements, rural recruitment and retention concerns, and the requirements of availability.
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> 7.4 The focus of this discontent is at the health authority level, as it interacts with its physicians and its citizens. Thus, Government needs to respond to the operational needs of the health authorities.
>
> 7.5 Government proposes that, notwithstanding its strained financial circumstances, it needs to begin to remedy these problems with additional resources.

In a radio program dated one week before the last provincial general election in June, 2001, the present Premier stated that "…someone in Victoria doesn't trust doctors…". He added that he does trust doctors.

What seems to have happened is that the Government, over many years with the best of intentions, and in the evolution of Medicare has assumed complete financial and administrative responsibility for the delivery of medical services in the province that were formerly managed largely by the medical profession. The Government reminds me of the person who bought a race horse without understanding how much it costs for stables, trainers, vets, hay, jockeys and all the other expenses that increase all the time while the commitment and the obligation continue. In this endeavour the Ministry of Health, unintentionally, I am sure, has alienated many members of the medical profession by tough or even intransigent administration and bargaining; by transferring much authority from doctors to administrators; by imposing rigid fiscal controls that seriously limit physician access to required facilities, by pro-rating or clawing back fee for service entitlement to which doctors responded with Reduced Activity Days ("RAD" days); by seeming to favour other segments of the health industry such as nurses, hospital workers and administrators, all of whom have received substantial pay increases; and by making "one off" agreements with some groups of physicians but not others. I regret having to say that every group of physicians

with whom I met during mediation, and the physicians who gave evidence at the arbitration, all expressed the same sense of frustration that is, to put it bluntly, most unhealthy.

In fairness, it must be recognized that the Ministry of Health is deeply offended by the conduct of some physicians who threatened to resign, and in some cases actually resigned, their hospital privileges and withdrew “on call” and other services during the currency of Master Agreements. In reply, some physicians allege extreme provocation on the part of the Ministry by prerationing fees and by requiring physicians to continue to provide services without compensation in the face of delays in implementation of on call payments. These delays took place in the face of increasing difficulties including a lack of access to hospital facilities, particularly hospital beds and operating rooms that have been closed for financial reasons. Government obviously believes there must be a significant re-organization of the delivery of medical services.

The total cost of medical services is naturally startling but doctors resent the criticism often made against them that they are

responsible for this escalation in costs. The only evidence we heard was that utilization of physicians may be increasing at the rate of 2% to 2.5% annually of which aging represents 0.5% and population growth 1%. There was no suggestion in the evidence that physicians are causing over-utilization of the Medical Services Plan.

I pause to say that we must not be deterred by the enormous numbers that arise for consideration in this case. Everything costs more these days and I cannot accept the bald assertion that the Government does not have the funds to pay reasonable compensation in view of the critical importance of the health system and the obligation the law imposes on Government to defend and protect Medicare and pay reasonable compensation to physicians. The financial circumstances of the Government are a legitimate factor to be considered, but that is not the end of the discussion, as we shall see. In fact, I have the view that Government cannot afford not to pay reasonable compensation if Medicare is to be defended as required both by law and the health needs of the public.

4.3 On Call and Doctor of the Day

On-Call and “Doctor of the Day”, two of the critical issues in this arbitration, are features of modern medical practice that urgently require attention. On Call requires physicians with hospital privileges - general practitioners and specialists - to make themselves available to provide medical services for patients in hospitals on rotations that vary depending on the number of physicians there are in a particular service. A physician on call must respond to telephone inquiries during his or her office time, during evenings, and during the night as may be necessary. He or she must attend at a hospital as required to provide service to persons who are probably not their regular patients. This disrupts office work and inconveniences office patients, many of whom have waited some time for their appointments. It compromises the evening and weekend relaxation and social activities of on call doctors because they must always be immediately available. It disturbs sleep, and compromises the doctor’s ability to function effectively the next day. The number of calls, of course, can vary widely, but it is not unusual for a physician to have several calls during the day, several during the evening and

at night, and to be called to the hospital from time to time throughout the day and night.

While ideal medical practice prescribes that on call duty should not exceed one day in five, we heard examples in the evidence of many of our most skilled surgeons being constantly on call because of the limited number of physicians in their particular service. For example, there are only 2 thoracic surgeons at the Vancouver Hospital so they take turns, week on - week off. Another highly skilled physician in the Fraser Valley reported that when he takes his son to soccer on Saturday mornings he must always make arrangements for someone to take his son home if the hospital calls, as frequently occurs. In rural communities, there are often insufficient physicians with hospital privileges to provide reasonable on call coverage. As a result, many physicians are on a one in two - or three - day rotation. Some doctors are on call every day of the year.

Until recently, there was no pay for on call service except that physicians actually called to the hospital could charge the usual fee FFS for services delivered there. Everything else, including stand-by

time where a doctor's time was not his or hers, was unpaid. This is starting to change, but uneasily. In 2000, some physicians in Prince George resigned their hospital privileges (permitting them to continue their office practices) but they refused to accept on call responsibilities except for emergencies. This continued for some time until a political settlement was reached which included very generous payments for on call service. This naturally resulted in similar demands being made by physicians in other communities and *ad hoc* settlements were made in some rural communities that are not as generous as the Prince George settlement. Thus, adjacent communities may have different or no on call arrangements. Many physicians have refused on call payment other than on the Prince George model.

We were given a recent example of on call difficulties in the summer of 2001 when some specialists in an urban community actually withdrew emergency services, excepting those required to save "life and limb", because their hospital, for financial reasons, repeatedly failed to respond to the doctors demands for payment for on-call and the establishment of an emergency operating room. This

withdrawal of service (on-call only), which lasted from August 1 to September 20, 2001, made it necessary for the hospital to transfer an average of about one patient a day to other hospitals, but the disruption of regular service and the effect on the public's perception of the health care system and the hospital was much greater than that. This withdrawal of service ended without any agreement for payment for on-call, but the hospital did agree to establish an emergency operating service so that such emergency cases would not displace regularly scheduled surgeries.

The Government recognizes the necessity of paying for on call services and has been making payments on a "patch work" basis estimated to be in the range of about $50 million for the current fiscal period. The Government has agreed that any increased award for on call services will be retroactive to April 1, 2001. On call service usually falls most heavily on specialists and rural practitioners in rural communities where there are limited numbers of physicians, but it is a burden to a greater or lesser degree on all physicians with hospital privileges.

"Doctor of the Day" is a practice that requires general practitioners with hospital privileges to be available to the hospital for 24 hours on a rotation that depends again on the number of available physicians to look after patients who require admission to hospital without an identifiable family physician. This burden increases as the number of patients arriving at hospitals without a family physician increases. A growing number of physicians, in order to avoid on call and doctor of the day responsibilities, have elected not to retain hospital privileges so their patients and others without a family doctor must be admitted and treated by the doctor of the day. Recently, some hospitals initiated a new program of employing what are called "hospitalists". These are physicians under contract to a hospital to discharge Doctor of the Day responsibilities. The Government proposes this function be included in its proposal for on call services and this probably indicates the way of the future in this respect especially for community hospitals with limited numbers of specialists.

I have no doubt that the Government has been alarmed by the limited withdrawals of service described above and seeks an award of this Board requiring physicians to sign contracts of service that will

not permit such withdrawals. This, also, will be discussed later in this Award. It should be noted, however, that the BCMA, as the other contracting party to the Master Agreements, has not condoned such "job action", nor have the great majority of BC physicians ever failed to provide on call or other medical services to the public as required.

Withdrawals of services, and the Government's stern response (after the initial, admitted mistake of signing generous "one-off" agreements to pay for on-call services in some localities, but not in others) are symptomatic of the problems on the physician side of the medical system. The physicians without on call compensation say the Government does not recognize the value of their services, that they are over-worked and underpaid and required to provide onerous on-call and other services free while nurses and hospital workers have received generous salary increases. The Government says it has no money for a general fee increase, that doctors are not overworked or underpaid anyway, and further that the doctors have wrongfully withdrawn services from the public. It says a covenant not to do so in the future is necessary.

As I have said, it is unnecessary for us to allocate blame for the distrust that now exists between the physicians and the Ministry of Health. As is often the case, there may well be fault on both sides, but that is not our problem. Our role is simply to assess the circumstances and attempt to answer the questions that have been referred to us regardless of fault. In this connection, however, we cannot ignore existing circumstances because we wish, if possible, to reach conclusions that will help to resolve, rather than make worse, the widening differences between the parties.

4.4 Some dynamics in the medical profession

It is obvious that medical services are far more expensive than Government wishes they were, and that the present system of health care cannot be sustained in the public interest without the co-operation of all components of the system, including the medical profession, the key service provider. That system is seriously at risk at the present time.

It is also obvious that the Ministry of Health is determined to

make substantial changes to the system of medical care in the province by offering some, but not all, doctors the opportunity to move from the traditional FFS to various forms of contractual relationships. Under the traditional fee for service system, which is specifically approved, but not required, by the Canada Health Act, physicians are paid for the services they provide. The more services they provide, and the harder they work, the more they get paid. This is the default system under which most physicians work at the present time, and it cannot quickly be changed without serious service disruption. In fact, it must be maintained and nourished until rational alternatives are identified and implemented which will take some time.

Under some Alternative Payment Plans (APP) now in place, physicians are paid a salary or fixed amounts for time-periods of service acceptable to them in hospitals and Health Centres and they are paid the contract amount regardless of their productivity or the energy they bring to the performance of their duties. At the present time, APP represents only about $200 million out of the physician's budget of $1.9 billion.

Quite recently, however, in order to retain some highly skilled physicians in teaching hospitals, arrangements called Clinical Academic Service Contracts (CASCs) have been made to transfer a limited number of specialists in teaching hospitals from FFS to generous contracts. These contemplate that these specialists will continue to provide clinical care, as well as discharge teaching and research and administrative responsibilities. These kinds of contracts may be the way of the future for specialists, but pending the outcome of these proceedings, no new CASC agreements have been made - causing even more frustration on the part of other equally talented and hard working physicians who believe they are entitled to the same kind of compensation as those few who already have such agreements. The BCMA does not question the right of physicians to enter into various kinds of contracts for medical services on a voluntary basis.

While touching on “change” I wish to say that the re-organization of health care financing is not within our mandate. The possibly limiting provisions of the *Canada Health Act,* which may

preclude private investment into the health care system, is not within our terms of reference. That question is being studied by others and we should say nothing about those matters at this time.

What is significant, however, and something that impacts on reasonable compensation, is the well-identified “sea change” in the attitude of some younger and possibly some older physicians. This was well described by Dr. Ayott, who does not question the commitment of young physicians to their profession, but recognizes that unlike his generation (who were trained in medical school to be workaholics,) the new physicians have different expectations. They are not prepared to work the kind of regimes that subsidize medical care with unpaid work at the expense of reasonable family life and recreation.

The profession and the public face a grave crisis in the diminishing supply of physicians. B.C. has for many years trained the lowest number of new physicians per population of any of the provinces with medical schools. In 1999, only 29.6% of our physicians graduated from the only medical school in the province at

the University of British Columbia, while 45.9% graduated in other provinces and 27.5% graduated in other countries. We have always recruited many physicians from other Canadian provinces, the United Kingdom, the United States and more recently from South Africa. It is said that northern BC would be largely without doctors if it were not for our South African physicians. Quite recently, the UK has announced it is seeking to attract a huge number of English-speaking physicians at very generous salaries. More significant still is competition from Alberta where, the evidence shows, there is an even greater shortage of physicians. The BCMA has demonstrated that physicians' total compensation in Alberta is higher than our own.

The Faculty of Medicine at UBC graduates less than 130 new physicians each year, about one-third of whom will probably return to their home provinces. This may partly be replaced by returning British Columbia students who take their medical training elsewhere but they may not come back if other pastures appear greener. While there are commendable plans to double the number of graduates at UBC, this cannot be done quickly and it will take from seven to ten years respectively, to prepare general practitioners and specialists for

practice. There will still be significant shortages when these new numbers of students start to graduate.

There are other difficulties on the physician-supply side. First, I have already mentioned that the current generation of physicians are not prepared to work the hours of their predecessors, and who can blame them, having regard to burdens of on call and less compensation than is paid in some other jurisdictions? Second, at least half the present students at our medical school are women. Experience shows that many women practitioners, and a good many men, do not work full time for a variety of entirely justifiable reasons.

As has always been the case, therefore, British Columbia must strive to retain our present physicians and attract large numbers of new physicians from elsewhere if we are to replace the 200 to 300 of our present aging physician population who annually will retire or reduce their practices over the next few years. Many specialist services and many communities are already under-doctored at the present time, and as mentioned above, upwards of 100,000 of our citizens are already without a family physician and are unlikely to

obtain one for the reasons already stated.

There is another problem with medical services at the present time. Access to hospital facilities is severely limited by shortages of operating theatres, nurses and hospital beds. This creates waiting periods for patients and frustration for physicians who cannot obtain access to sufficient resources to provide the services required. The causes of this are shortages of staff (mainly nurses) and financial constraints that are another example of medical services costing a great deal more than government would wish.

Probably more important than most of the foregoing, except compensation, is the serious mistrust that has been generated by a decade of administrative conflict. There is no need to itemize the many complaints the physicians have with the Ministry of Health, but it must be recognized that the Ministry has a near-mutiny on its hands that can no longer be ignored. Moreover, cataloguing physicians' complaints would not tell the real story. We heard the evidence of 14 representative physicians who explained the extreme difficulties of practice under the present regime. These are well trained, highly

skilled, and totally dedicated family doctors, specialists, and public health officers. They described unmanageable work loads, bureaucratic difficulties, and disillusionment about their profession. It will be useful to furnish an outline of their evidence, which is found in Appendix A to this Award.

On the other hand, Government must prioritize its limited resources, and physician compensation is an important but not its only responsibility. Government must be given an opportunity, ideally with the co-operation of the profession, to undertake such reasonable re-organization of the delivery of health services as it thinks necessary, but it must get its own house in order first.

It cannot be disputed that there is a serious problem of physician shortage in BC that can only be solved by attracting more physicians to practice here and that is not likely at present compensation levels. It is hoped, as several physicians have mentioned, that both sides will treat this mediation-arbitration process as a new beginning in their relationship and that British Columbia will again become a magnet attracting qualified practitioners from all over

the world. Throughout the mediation process I urged the parties to make gestures of understanding but that could hardly be done when the Government would not discuss the crucial question of compensation, which was the principal purpose of the mediation.

A continuation of suspicion and lack of trust between Government and the physicians, and a continuation of the ten year dispute over compensation will make recruiting physicians even more difficult than is now the case. The medical ship must be made seaworthy before new, urgently needed crew members will sign on.

This Board must now state its views on these perplexing problems.

5. The questions referred by the parties to this Board of Arbitration

A. Compensation:
(i) What methodology, consistent with the terms of reference, should be used to determine “reasonable compensation” for British Columbia physicians?

The BCMA submits that comparability with physicians in nearby

Alberta, who most recently obtained a substantial fee increase is the preferred methodology because to the greatest extent possible, reasonable compensation must be moved to a level where the province can retain its existing physicians and at the same time recruit the new physicians needed to provide adequate medical services to the public. In addition, it is apparent that present levels of compensation contribute in a very meaningful way to loss of mutual trust and confidence between the Government and the medical profession. In the 2001 settlement of the nurses' dispute the Government explicitly accepted Alberta wage scales as the benchmark and the doctors expect the same treatment.

The Government submits:

> The basis for reasonable compensation is constructed by comparing physician compensation in two settings: first, between B.C. and other provinces …, second, within B.C. relative to other publicly-funded groups. (Government Brief, p. 59)

As can be seen, there is very little difference between the parties on the first part of the Government's position. We heard very little about compensation levels in other provinces beyond Alberta. We know that the Ontario physicians' contract has a re-opening

provision that kicks in next year. In view of the national competition for physicians, it is unlikely, in my view, that Ontario physicians, any more than British Columbia physicians, will accept less than what Alberta doctors are paid. It must be remembered that Ontario is where a great many BC physicians have always been trained and BC will not be competitive if its fee schedule is not comparable to both Ontario and Alberta.

In a 1999 Manitoba arbitration, the Board referred to what it called the “Ontario/Prairie Average” (including Alberta) as an aid to determining compensation for Manitoba physicians. It commented, however, that comparisons with other provinces, such as the Maritime Provinces, British Columbia, and the USA were not helpful. I have already mentioned the importance of Alberta, BC’s closest neighbour and competitor for physicians. I have no doubt that Alberta clearly provides the best guide to reasonable compensation at this time. As in the Manitoba case, I do not think comparisons with other provinces will be helpful, and although it was mentioned that compensation is 40% higher in the United States than in BC, the evidence we heard was not sufficient to permit a detailed comparison.

In my judgment, comparability with Alberta also best satisfies the multiple objectives described above. The present and increasing shortage of physicians is a major contributing cause to doctors' dissatisfaction and disillusionment and recruitment and retention are critically important to the maintenance of our health system. British Columbia must regain its former position as a preferred place to practice before structural reforms to the delivery of medical services can be expected to succeed. I do not consider comparison with other publicly-funded groups to be a tenable argument, but I shall return to that subject later.

I should next deal with the submission of Mr. Harris on the principle of "replication", which he described as an approach to this question that looks at the history of a relationship, and proceeds incrementally. He says that because physicians' fee increases over the past several years have been modest, including a 2% increase in 2000, there should be only a modest increase at this time and that the Government's present offer of 6% of new money for non-fee items, satisfies this principle.

With respect, I am not able to accept that submission. Without pronouncing in any way on the replication principle which may be useful in some circumstances, I doubt if the recent history of these parties is useful. While accepting a 2% increase in the Framework Agreement, the BCMA achieved a major breakthrough and a departure from the past by the agreement of the Government to mediate and arbitrate both the troublesome question of on call and reasonable compensation. The BCMA accepted the 2% increase expecting that reasonable compensation would quickly be established under the new regime. To hold the parties now to an historical limitation would further stultify the present situation and only invite more discord and disaffection.

Moreover, I think a replication theory could only be a useful concept in static circumstances where there is no reason to depart from an historical pattern. In this case, the health-care system is in crisis because Alberta has broken out of its historical pattern causing great difficulties for everyone in recruiting much needed new physicians. Many of our physicians are leaving or retiring; on call is

now going to be paid and its parameters must be established; reasonable compensation must be fixed; and mutual trust and understanding must be re-established. This is no time, in my view, to hope that a repetition of the past will solve either our present or the future problems.

> **The answer to question A (i) is comparability with Alberta now. In the competitive world this also probably means comparability with Ontario over the term of the contract but it is not necessary to go that far.**

A (ii) In the event it is necessary to compare the compensation of physicians in one jurisdiction to that of another, what model should be used for that comparison?

The BCMA has submitted a Report, "Compensation Comparison" (with Alberta) prepared by Jim Aikman, Assistant Director of the Department of Economics and Policy Analysis for the BCMA. He was the principal economic witness for the BCMA at the arbitration hearing. Because there is unchallenged evidence that the population of BC includes 3% more persons over 65 years than Alberta, and because there are substantially different numbers of populations and physicians, and because there are differing numbers

of physicians working less than full time in both provinces, he concluded that the best model for comparison is full-time physicians in each province. The Canadian Institution for Health Information (CIHI) has concluded that physicians with incomes above the 40th percentile can safely be assumed to be working full-time. Mr. Aikman accepted that assumption. He then determined average annual physician compensation in the two provinces including the substantial recent fee increase in Alberta, and he made adjustments for differences in non-FFS income, benefits, overhead and cost of living. He concluded that Alberta general practitioners earn 28.9% more than BC doctors, and Alberta specialists, on average, earn 34.7% more than BC doctors. Mr. Aikman's comparable Tables are set out in Appendix "B" to this Award.

The Government did not accept Mr. Aikman's compensation comparison with Alberta. It attacked Mr. Aikman's assumptions and some of the components of his comparison and applied some different assumptions of its own. It also argued that total cost per physician and comparisons with other public service employees furnished a better measure of reasonableness.

I am satisfied that an adjusted comparison with Alberta physicians' total compensation is the best model for determining reasonable compensation in the circumstances of this case, and I shall deal with all these arguments in the next section.

The answer to question A (ii) is that an adjusted comparison with compensation paid to full time physicians in Alberta is the best model for determining reasonable compensation.

A (iii) Based upon the terms of reference and the answers to (i) and (ii), what adjustments, if any, should be made to total compensation for B.C. physicians? What percentage change, if any, should be applied to the compensation of general practitioners in BC? Of specialists in BC? What should be the rates of compensation for salary, service and sessional contracts?

This question really has two parts. First, it asks about reasonable compensation for general practitioners and specialists, and posits an answer in a percentage change, if any. The second part asks for rates of compensation for salary, service and sessional contracts. I will attempt to answer these two different questions in the order stated in Question A(iii).

First, then, as already mentioned, Mr. Aikman filed an economic analysis of physicians' FFS income in Alberta and British Columbia. Using the most recent 1998 report of CIHI, he started with the average income for full time General Practitioners and the 19 categories of specialists in BC and Alberta. It is notable that the 1998 gross incomes were roughly comparable for general practitioners and for five categories of specialists (psychiatry, obstetrics, orthopedic surgery, pediatrics and internal medicine). For the other categories, BC physicians were higher (by about $50,000) in neurology, neurosurgery, and urology, while Alberta physicians were significantly higher in the remaining specialty categories.

Mr. Aikman then made adjustments for provincial differences such as payments received in one province but not the other (ie. WCB and ICBC revenue in B.C), variable benefits, fee changes, overheads and cost of living, and most significantly, the recent Alberta fee increases, to reach comparable figures for full-time physicians in the two provinces.

On this basis Mr. Aikman calculated that a 28.9% increase for

FFS compensation for BC general practitioners and an average of 34.7% for specialists is required for comparability with Alberta physicians. The actual rate of required increase for specialists varies from 12.9% for pediatrics to 68.2% for physical medicine.

Subject to what follows, I find Mr. Aikman's methodology persuasive.

It should be mentioned that there is a "hard" cap on the recent Alberta fee increases and those increases could possibly be reduced if demand for services exceeds budget. Mr. Aikman said, however, that this cap would not reduce the Alberta increase below 21.3%. I understand the right of the Alberta Government to pro-rate is now under arbitration.

The Government in its written submission argued that, (a) the financial circumstances of the province preclude any general fee increase at the present time except as mentioned below; (b) that BC physicians are already paid more (from 7% to 30.2% - 10.9% for Alberta) than in other provinces; (c) that BC spends more *per capita*

on medical services than other provinces; (d) that BC physicians work less (from 0.7% to 61% - 13.1% for Alberta) than physicians in all the other provinces; (e) that former fee increases of 2.5% over the last three years compare favourably with those received by other public sectors workers and; (f) that other provinces would have to increase their fees (from 12.4% to 50.2% - 15.7% for Alberta) to match a suggested BC fee increase of 6.1%. The Government also questions Mr. Aikman's adjustments for cost of living and overhead.

Most of the above numbers are derived from Tables included in Chapter V of the Government Brief. It appears that the Government's Brief is based in part on a workload theory I do not accept, and that it does not in all respects take into account the substantial fee increase recently made in Alberta, but I shall come to that in a moment.

I propose to deal with the Government's argument based on financial circumstances at the end of this part of my Award. It will first be convenient to deal with the Government's response to Mr. Aikman's calculation in the context of the evidence of Professor Beck, who gave evidence on behalf of the Government. He has a PhD in

economics from the University of Alberta and he is currently a professor of economics at the University of Saskatchewan. He was the Government's principal economic witness on medical matters. He has enjoyed a long and distinguished career studying and advising on medical economics, including the Hall Royal Commission Reviewing Medicare in 1979.

Professor Beck offered three main criticisms of the Aikman comparison which he dealt with in the following order: first, workload; second, cost of living; and third overhead.

1. Workload

Dealing first with workload, Mr. Aikman adopted the CIHI assumption that physicians earning above the 40th percentile were working full-time. Professor Beck does not believe all full-time physicians are working at or near capacity, and he argues that "…physicians above the 40th percentile would have a wide range of volume of services, volume of patients, mix of services and so on." This is recognized in a CIHI study, Full-Time Equivalent Physicians

Report Canada, 1996/97 1998/99 at p. 5. But Professor Beck at Transcript p. 1212 recognizes that CIHI characterizes full-time physicians as all those who earn more than the 40th percentile. The CIHI Report, of course, was prepared not for purposes of comparing compensation, but rather for calculating physician supply. To this end, it developed the notion of "full-time equivalent", which is a process for including the contribution of less than full-time physicians in the survey of available physicians' services in Canada. The report, also at p. 5, states that "…it's statistics are not suitable for any time series analysis as the sub-set of physicians earning in excess of any fixed dollar benchmark will be affected over time by increases in the provincial schedule of benefits. As well, interprovincial comparability will be weak because of differing benefit levels among the provinces." (emphasis added)

Thus, in its ongoing study, CIHI recognizes the volume of services of a physician in the 40th to 100th percentile in the notion of a full-time equivalent, using a linear progression across the benchmark area (40th percentile).

Moving upwards on the income scale it uses a logarithmic weighting which tries to recognize workload and supply differences.

Thus, for purposes of physician supply, every one earning between the 40th and 60th percentile is regarded as one FTE, and that kind of calculation, of course, is specific to a particular province but for the purposes of his evidence, Professor Beck found that using the 60th percentile instead of the 40th made no significant difference.

I am not persuaded a dichotomy between compensation and physician supply is a useful one. No one can dispute that some physicians work and earn more or less than others. Income depends on many factors of which work intensity is one, but there are others such as the volume of available work, and the value and mix of the work being done, which will inevitably vary between individuals, and possibly more greatly between a highly skilled specialist and a general practitioner just starting out in practice. But with respect, I see no profit in measuring the number of required FTEs when our purpose is to determine whether physicians, generally, are working full-time or part-time. The line has to be drawn somewhere and I am

content to accept the line suggested by CIHI and adopted by Mr. Aikman. But as will be seen, the calculation of workload does not take us very far.

Professor Beck explained his approach to workload in a 4 line table (V.5.A from the Government Brief), which is said to be based on CIHI information. The four lines for B.C. and Alberta are as follows:

	BC	Alta.
Avg. income/full-time MD	249,940.00	260,739.00
Avg. cost/service	41.64	38.41
Avg. services/full time MD	6,002.40	6,788.10
Workload as % in BC.	100.0%	113.1%

The rest of the table furnished the same figures for all the provinces, showing that not only Alberta physicians, but the physicians of all the provinces carry a heavier work load than BC doctors, ie., 13.1% in Alberta; 0.7% in Quebec, 46.3% in Saskatchewan, 38% in Ontario, and the highest, 61% in PEI. I digress to say that apart from a comment from Professor Beck that Saskatchewan doctors are “driven to tatters”, there was no evidence supporting this remarkable and highly theoretical calculation. There is persuasive evidence that BC doctors are seriously overworked.

Professor Beck explained the above table. The first line is the average income of all physicians in each province. This includes both general practitioners and specialists which raises doubts about its usefulness. It shows average physicians' income is about $11,000 higher in Alberta than in BC. The second line is CIHI's estimate of the average cost per service in each province that is calculated by reference to the fee schedules, not experience or actual cost. The third line is a derivative line created by dividing line 1 by line 2. On this basis, he calculated, as shown in the Table above, that the average physician in BC delivered 6042.4 services while the average physician in Alberta delivered 6,788 services. The fourth line simply expresses the third line in index number form.

Professor Beck also referred to another table described as "Workload Assumption Sensitivity Analysis". It adopts the Aikman calculation, but removes payments for the previously calculated 13.1% Alberta increased work-load in order to retain comparability. In other words, the calculation reduces the Alberta income by the value of the alleged extra Alberta workload. When this is done, the

amount required to be paid to BC physicians in order to reach equality with Alberta physicians is reduced from 29.3% for general practitioners to 20.0%, and from 35.2% for specialists to 21.8%. This calculation, expressed in dollars, would reduce the amount BCMA says is required to achieve parity by a substantial amount but it confirms the “Alberta Advantage”.

I turn to consider the BCMA response to the Government’s workload submission. First, the Government’s calculation that Alberta physicians would have to be paid 10.9% more to enjoy equality with BC physicians was shown to be based in part on the work load comparison described above, including an average price per service of $42.16 to which I shall return in a moment. But even assuming that price is valid and correct, it was conceded by Professor Beck that the calculation does not include the recent 22% fee increase negotiated in Alberta. Factoring that fee increase into this calculation would make a difference in favour of BC physicians of about 21%. On that basis, Alberta physicians’ compensation would still be 11% ahead of BC physicians (from minus 10.9% to plus 11%), and more than that if the workload differential is eliminated.

Professor Beck also conceded that his calculation is based entirely on price or fees, and is not affected in any way by overhead or cost of living that, if validly claimed, could only favour BC physicians further.

Returning to the workload theory, it seems clear that it is based on fee rates (not fees actually earned by delivering medical services), and the number of services is the result of dividing the average fee schedule cost into average income. What Professor Beck is saying, as I understand him, is that if a physician billed $100,000, and the average fee cost for every service in the province was $100, then the number of services performed by the doctor would be $100,000 divided by 100, or 1,000 services - regardless of the mix of fees actually charged by the physician for medical services.

Average fee cost is said by CIHI, and agreed by Professor Beck, to be calculated for each of 96 categories of medical service. For each category there is a number of fee items. The average of those fee items divided into the number of services is the average cost, ie. $41,64 for BC and $38.41 for Alberta. But the fee items, and the mix of usage of the various items is different in each province

and there has been no weighing of the numbers for these differences. The end product would necessarily be different if there were such weighing. As Professor Beck said at T. p. 1314 “If the mix were different, you would get a different average in that category.”

Next, Professor Beck was referred to p. 9 of the Physician Services Benefit Rates Report (PSBR), which states:

> Provincial fee schedules contain preambles that detail billing rules, which are often the subject of government and medical association negotiations. Some preamble rules may place limitations on the frequency of specific services or the conditions under which services are or are not payable. <u>It is beyond the scope of the PSBR system to measure the effects of all preamble rules on average reimbursement levels.</u> (emphasis added)

Professor Beck was asked whether his report made adjustments for different billing rules in different provinces for post-operative attendances, for hospital visits, supportive and home visits and nursing? He did not know, but counsel stated the report makes no such adjustments. I understand there are different provincial rules for billing these services.

Returning to the workload calculation, Professor Beck gave this evidence:

> Q. Now, if your average cost service figures in that second line are skewed in some way, then obviously the percentages on the bottom line would be skewed – without directing whether they are or they're not – just as an arithmetic issue?
>
> A. If both provinces are skewed the same way, skewing wouldn't be too much of a problem.
>
> Q. But if you had a drastic difference, for example, in the mix of services between the provinces, then that would result in a difference in the bottom percentages. Right?
>
> A. Yes.

In argument, counsel referred to the evidence that 3% more of the population in British Columbia is over 65 years and they take longer to treat than younger patients, and to the more than $100 million paid to physicians in BC for non-FFS work under various kinds of contracts for which there are no corresponding payments to physicians in Alberta as examples of factors that could "skew" the workload calculation because they each operate to reduce the number of services billed in BC under FFS.

Next, Professor Beck was asked about a document presented by the Government as part of its submission in proceedings before the BC Medical Services Commission in 1998 which is the base year for the CIHI study. This Government document stated that the average hours worked per week were essentially the same in Alberta, Ontario and British Columbia. There is another document prepared by the CMA that stated BC physicians worked longer hours in 1998 than Alberta physicians. Not being familiar with the first such document, and its context, Professor Beck could not comment in detail. But when asked if the difference between the provinces shown on his workload comparison could be explained by differences in population demographics, he replied that if the hours of work were the same, the differences could be explained by a variety of things.

After Professor Beck agreed that he had directly related hours of work with gross income, and that there is also a link between income and the mix of work, he was asked:

> Q. …you could have two people sitting in their office – two doctors in their office --- just by way of example –doing the same number of visits per patient, but if the fee schedule is different for those visits, then you would have different incomes?
>
> A. You would have different income.
>
> Q. But you would have the same workload, essentially?
>
> A. Yes…

Upon a consideration of all of the evidence, I am not satisfied the workload comparison accurately compares medical practice in BC and Alberta or the other provinces. Apart from the questionable assumptions on which it is based, there is unchallenged evidence that BC doctors are working very, very hard, so hard in fact that many general practitioners cannot take on more patients. Moreover, the statistical conclusion based on doubtful assumptions that doctors in all the other provinces are working harder by up to 61% without a word of specific confirming evidence about the physicians of any other province is not persuasive. As Mr. Aikman said in his evidence, it is often useful to do a "reality check" to see if the result of an investigation is reasonable. He finds it hard to believe that full-time physicians in PEI are working 61% more than BC full time physicians.

So do I, even though it is true that there are fewer doctors per population in PEI than in BC. We do not know, for example how much time doctors in other provinces spend on call, or as doctor of the day or for travel between hospitals, to mention just a few factors that could also skew this analysis. The unusual result of this statistical analysis of workload for all provinces questions the validity of the process and reminds me of the maxim that, when the clock strikes 13, everything that has gone before becomes suspect.

I am far more persuaded by the direct evidence of BC doctors about their workload, which was not contradicted, by the absence of any evidence about work load in other provinces and by the Government's own publications about hours of work, than I am by a doubtfully premised statistical analysis.

2. *Cost of Living*

Professor Beck next turned to the cost of living adjustment of 13.37% included in Mr. Aikman's report. Mr. Aikman's theory is that it costs BC doctors 13.37% more to live and practice in BC. He calculates equality of income with Alberta physicians can only be

achieved by increasing BC physicians' income by those amounts.

Professor Beck explained that a cost of living allowance is usually regarded as an increment to cover the loss of purchasing power resulting from inflation. On the other hand, a relocation allowance is sometimes paid when a person moves to a more expensive province, but once it is paid, it need not be paid every year. He gave an example of a doctor being persuaded to move to a province where the cost of living, on a $100,000 salary was an additional $20,000. If the relocation salary is fixed at $120,000, then the salary reflects the increased cost of living in the new province, and increases in subsequent years, if any, should be limited to conventional adjustments for inflation.

Professor Beck also criticized the inclusion of a number of items in the cost of living analysis offered by BCMA, such as capital items for housing and taxation. He also said that the burdens of living cost must be assumed to have been built into a fee or compensation system over time. That is difficult to accept in this case because fee increases since 1998 total only 2.5%.

Professor Beck calculates that disallowance of the cost of living component from the BCMA calculation would reduce the amount required to achieve parity with Alberta in the first year of the contract by an amount in the order of $204 million.

The response of the BCMA on cost of living was two-fold. First, it referred to the seminal report of Mr. Justice Emmett Hall on Medicare in 1980 where he said:

> I do not advocate a national fee schedule for payments for physician's services…There are differences across Canada in financial expectations, costs of living, and costs of practice which make a single schedule for the whole country impractical. (emphasis added)

Second, the BCMA argued that the focus of the negotiations between these parties has been first to provide reasonable compensation, and second to ensure that, to the greatest possible extent, BC will be a competitive market for the retention and recruitment of the physicians needed to properly serve the health needs of the public. In this respect, it was argued that doctors practicing here, and those we wish to come here, will know that their compensation is equivalent, in real terms, to what can be earned

elsewhere. Whether this is in lower cost of living, or in income to pay extra costs of living is immaterial when viewed from the prospective of a family budget.

With respect, I do not accept the view that the extra cost of living between BC and Alberta is not a factor bearing on reasonable compensation in the sense that it affects the amount a physician and his or her family has to spend at the end of any period. I do agree with Professor Beck, however, that once factored into an income in order to achieve parity, continuing differences in cost of living would not be added to income annually except possibly as an adjustment reflecting changes from year to year. To do otherwise, would be double counting.

I am troubled, however, by the question of whether differing levels of cost of living are, strictly speaking, a compensation item. I will have more to say about this question when I come to consider the financial circumstances of Government later in this Award.

3. Overhead

Again, the Government position is that overhead is included in the fee structure and differences, if any, should be related to the rate of inflation. With respect, I am unable to accept that argument because it does not respond realistically to the cost of practice referred to by Mr. Justice Hall, or to the amount BC and Alberta doctors (and their families) should each have at the end of the month or year as disposable income. For many years, the Government has published a "Blue Book" that lists the compensation paid to each physician. Most physicians regard this as unfair as it makes no allowance for the overhead costs of operating a practice, and leaves the physician with much less real compensation than the published amount. Moreover, a doctor considering settling in BC would want to be assured that he or she would not suffer a direct or indirect income loss on account of overhead by choosing to practice in this province.

The amounts claimed for overhead in BC and Alberta were independently calculated by independent researchers retained by the BCMA. The Government did not provide any contradicting evidence

on this question.

Again, however, it seems to me that an adjustment for overhead should not be repeated each year because once the overhead difference is recognized in the first year, it becomes a part of the fee schedule as described by Professor Beck, and once parity is achieved by a first year salary adjustment, any subsequent adjustments for overhead should only be for actual changes. Mr. Aikman estimates a forecasted increase in overhead in BC during 2001 – 02 at 4.14% and there is no evidence to the contrary.

There were arguments made that overhead cost should “flatten” as income rises and there is a claim by BCMA that calculated overhead will increase for inflation in 2002-03 by 4.14%, and we have no evidence about the likely cost of overhead in the following year. These are matters that the parties should discuss before we make a final decision on the impact of overhead on reasonable compensation.

My conclusion on all of the above is that the Aikman report furnishes the best comparison between BC and Alberta, but it must

be modified for the reasons I have mentioned and for other matters I am about to discuss. In addition, I am not able to assess the impact that some of the matters I will be mentioning below will have on reasonable compensation. Just as we were unable to complete our mediation on the subsidiary agreements without knowing the impact of the compensation question, I find myself unable to form a final view on compensation without knowing the impact of some of these other questions.

Considering all the evidence, particularly the recognition of Professor Beck just mentioned that even on the basis of his workload theory (which I have rejected), Alberta physicians are earning and will earn at least 11% more than physicians in BC over the term of the new contract, I conclude that BC physicians are entitled to an immediate interim award for increased compensation staged as the Alberta increases were. Before giving a final answer to this question, however, I must deal with some other Government submissions.

First, the Government argued that B.C. spends more per capita on physicians than other provinces. Our task is not to determine

cost, but rather reasonable compensation. The average amount expended on each physician may not be a measure of compensation for most physicians because it does not make adjustments for the costs of practice including the extra cost of caring for BC's aging population many of whom have special medical needs. *Per capita* comparisons with other provinces do not take these differences into account.

Second, the Government argued that comparisons with other publicly funded agencies do not support more than a 6% increase in total compensation for physicians. Such proposed increase is earmarked largely for recruitment, retention and limited on-call payments without any income increase for FFS physicians. The information we were given shows BC physician fee increases since 1989 have been in the range of 22.4% while nurses have received increases of 43.79% up to 2001 and they have gained a further increase of 23.5% to be paid between 2001 – 2003. Hospital workers' increases in the same period have been in the range of 52.8%.

Apart from that, with respect, I do not consider this to be a useful comparison. Instead, in my view, the comparison must be between doctors, and that can only be done by looking outside the province, especially when BC is competing not just nationally but also internationally for the new physicians needed to keep our health system functioning.

I believe this will be a right time to consider the other qualifying considerations prescribed in the Framework Memorandum, particularly the financial circumstances of the Government and the operational and medical resource needs of the Health Authorities. For convenience, I shall re-state the relevant passage:

> …the terms of Reference of such an arbitration will include the objective of being consistent with the law and the terms of the Master Agreement, reflecting the financial circumstances of government, the need to provide reasonable compensation for the services rendered, and the operational and medical resource needs of the Health Authorities.

I observe, however, that the first requirement is consistency with the law and the Master Agreement. As already mentioned, the law as stated in the *Canada Health Act,* the *Medicare Protection Act,*

and the current Master Agreement expressly prescribes “reasonable compensation” for physicians. The structure of the *Canada Health Act* makes it clear that reasonable compensation is necessary to ensure public accessibility to proper health care. Mr. Harris argued on the basis of the evidence of several medical witnesses that paying doctors more will not ensure better access. I understand his point is that if physicians are not paid more than at present, Government will have more money for staff and facilities enhancement. The answer to that is three-fold. First, there is no assurance Government will use those savings for that purpose; second, physicians should not be expected to subsidize a similar but distinct Government responsibility; and third, since a great deal of health care is provided by physicians outside of hospitals, improved staff and facilities will not enhance accessibility if inadequate compensation causes a further reduction in the number of physicians who can be attracted to BC.

In my view, the Government has a concomitant responsibility to provide adequate facilities for the maintenance of proper health care – also for the purpose of ensuring accessibility - but that does not excuse it from providing reasonable compensation. In fact, I would

have thought that the express statutory direction for reasonable compensation and the inclusion of that phrase in the terms of reference might give preference to compensation over the requirements of the Health Authorities. But it is not necessary to make than kind of distinction. Both are important and they may be entitled to equal weight even though it is apparent that facilities without doctors would not be a sensible solution to this vexing problem. I pause to observe further, that a sufficient supply of skilled physicians is as much an operational and medical resource need of the Health Authorities as hospitals and other facilities.

At the end of this part of the analysis, I accept that reasonable compensation and Health Authority needs are equally important, but they are both the responsibility of Government and the assumption of multiple responsibilities does not ordinarily reduce the burden with respect to any of them. We are only involved in the determination of the foregoing, and we cannot do anything about the latter. In addition, we have no evidence of what those needs are or by how much, if at all, reasonable compensation should be reduced because of such needs or how we would “reflect” such needs in our award.

Surely they are subsumed in the other qualifier, namely, the financial circumstances of Government.

Reflecting the financial circumstances of Government (not the Province) in the determination of reasonable compensation is much more difficult. It is a notorious fact that these are difficult times for the Government, which is restructuring its financial circumstances both on the revenue and expense side. For many years, the Government has financed medical services by a combination of revenue and deficit financing. It now faces a self-imposed obligation – that it can defer or change – to balance its budget by 2004, which is beyond the term both parties suggest for the term of the Agreement we are considering. Also, Government determines its own revenue by its taxing policies. There is no doubt that Government can fund any award we may make by a variety of means at its disposal, painful as they may be.

Financial difficulties are not a new phenomenon in this kind of a problem. In the private sector, inability to pay increased wages or salaries can be established by an examination of financial

statements. That is not the case with Government, which can run temporary deficits or increase revenue as required. Moreover, its revenue comes from so many different sources that forecasting is seldom precise. In addition, Government recovers a portion of every dollar expended for physician's compensation through its share of income and other taxes.

While the evidence we heard was neither optimistic nor entirely gloomy, economics tend to be cyclical. The present depressed cycle began in the United States in March, 2001, and it is expected to turn upwards not later than March 2002. Mr. Paul, the Government financial witness predicts improved GDP levels in 2003. The Government has confidently predicted increased revenues as a consequence of the recent income tax reductions and improved investment, but we have no way of knowing if those happy events will materialize. If they do, there would be no reason to award less than reasonable compensation.

More seriously, Government has not attempted to establish any particular scenario that would assist us to reflect its financial

circumstances in our award. Government does not say it cannot pay more – it proposes additional expenditures amounting to an estimated 6% or $115 million - but nothing for FFS physicians. Assuming, for the purposes of the argument that comparability with Alberta is the measure of reasonable compensation, and assuming such comparison suggests a *percentage* increase for BC physicians, by what amount should we reduce physicians' entitlement? We could pick a number, arbitrarily, such as 25%. But what would the rationale be for such a reduction? There is no reason in the evidence to believe that the financial circumstances of Government permit a non-fee award of 6% but they do preclude any fee increase. That would require a conclusion that present compensation (plus 6% for non-fee items) is reasonable compensation in the present circumstances of the Government notwithstanding the resulting disparity with Alberta. I think, with respect, that that would be legally wrong and would lead to further deterioration in the quality of health care medical services which the Government is pledged to maintain.

Faced with these imponderables, I am driven to balance two possibly incompatible provisions of our terms of Reference. On one hand, we are required to fix reasonable compensation that reflects the financial circumstances of Government but we must keep in mind that we are not dealing with an economic snap shot at any particular date but rather over a two and a half or three year period. On the other hand, our award must be consistent with the law and the Master Agreement which, as already described, requires reasonable (not discounted) compensation.

When the former is uncertain, and the latter is unqualified, we are constrained to determine reasonable compensation objectively on the evidence. But we cannot ignore the words of our jurisdiction which requires us to reflect the financial circumstances of Government. Regretfully, I think this can best be done by disallowing the BCMA's claim for cost of living in the compensation comparison with Alberta even though, as already mentioned, I believe compensation is affected indirectly by the higher cost of living when compared with Alberta. I chose this method to reflect the Government's financial circumstances because cost of living is a

societal rather than a compensation issue and it relates only indirectly to compensation. Everyone who lives here pays the price for doing so, and for the same reason that I do not think the physicians' should be expected to subsidize Medicare, the public should not subsidize physicians' cost of living. Government, must decide whether, as a matter of policy, it should include a cost of living component in physician's compensation for the purpose of retaining and recruiting much needed doctors.

I would not make any further deduction because of the financial circumstances of the Government. Health care is a frequently announced priority of the Government. It settled a substantial pay increase on the nurses and health-care workers. It has recognized the need to pay on call. The Health Authorities have made generous agreements with some key surgeons it must retain in the public interest. The Government has been paying, and is offering increased retention and recruiting payments. Notwithstanding its financial circumstances, Government obviously understands that the system is in crisis and at risk of losing irreplaceable physicians. While Government has the right to settle priorities, it has exercised this right

by agreeing to this method of resolving this urgent social problem and cannot expect that it would seek on one hand to arbitrate reasonable compensation and then say on the other hand that reasonable compensation cannot be paid because of its financial circumstances.

After giving this question the most careful thought, I remain satisfied that the financial circumstances of the Government, serious as they may be at this time, do not excuse the Government from its statutory duty to pay undiscounted reasonable compensation not including cost of living, and that that can best be determined by comparison with Alberta physicians. Alberta is our closest neighbour and strongest competitor for physicians, and other provinces must be expected, over time, to match the Alberta standard in order to recruit and retain the physicians they need. Moreover, as the shortage of physicians is said to be world-wide, and as there is already a growing shortage of physicians in almost every province, substantially increased compensation is necessary to satisfy the legal and contractual criteria I have described.

Before reaching a final conclusion on reasonable compensation however, it will be useful for the parties to resume negotiations on overhead and other parts of Phase I in light of the directions contained in this interim award. Our final conclusion on total compensation will depend in part on what is decided on some of the other questions referred to us for decision. If the parties are not able to reach agreement, then this Board will proceed to pronounce finally on all these matters.

There is evidence that the Alberta increase was staged with 6.26% being paid from April 1, 2001, a further 5.1%, compounded, on Nov. 1, 2001, and a final increase of 9.15%, compounded, on April 1, 2002 for a total increase of 21.9% all subject to a possible .68% reduction for pro-rationing that is now under arbitration. I would make an immediate, interim FFS award of 11.3% for BC physicians retroactive as to 6.2% from April 1, 2001 and a further 5.1% compounded from November 1, 2001. I leave for further consideration the further increase payable in April 2002 pending further negotiations on overhead after the first year of the contract.

The answer to the first part of this question is that BC physicians (general practitioners and specialists) receive an immediate interim FFS award of 6.2% from April 1, 2001 and a further 5.1% compounded from November 1, 2001; that the parties discuss the allocation of the specialists portion of the award; and that the matter be reviewed by us after the parties have had a chance to negotiate further, on other items and after the following matters are resolved. This award could be further adjusted when the pro-rationing dispute in Alberta is resolved.

I will repeat for convenience the second part of this Question A(iii):

What should be the rates of compensation for salary, service and sessional contracts?

The BCMA says that no direct comparison with Alberta is possible in this context because 98% of all physician's compensation in Alberta is FFS. The BCMA argues that the comparison should be made with FFS physicians, after adjustment for comparability with Alberta since the levels of expertise are the same regardless of the payment modality being considered. The BCMA further argues that Rural Incentives should not be considered in this analysis as they are paid to a relatively few doctors and should properly be additional to

proper compensation.

The BCMA's primary submission is that we should not attempt to determine salary levels at this Phase of the Arbitration because it must be related to the FFS rate paid to general practitioners and specialists, and because of the detail and complexity of fixing salary scales. Alternatively, BCMA submits that if this item must be concluded in Phase I, that a point system should be established that would recognize years of practice, additional training, and supervisory/management responsibility. Then, using the points assigned to each practitioner, the BCMA proposes a salary scale with four steps for each of general practitioners and specialists based on the points earned on the first stage of this analysis. The salary scale rounded to the nearest $1,000, proposed is as follows:

Points	**G.P. Services**	**Specialists**
Step 1: 0 – 5	$168M to $268M	$201M to $401M
Step 2: 6 – 11	$184M to $284M	$212M to $421M
Step 3: 12 - 17	$203M to $303M	$243M to $448M
Step 4: 18 – 26	$223M to $326M	$268M to $468M

The BCMA also proposes a salary for purely administrative physicians to be negotiated between $142,000 and $500,000, but this

may not require further attention in view of my conclusions later in this Award about the scope of our jurisdiction. The BCMA also proposes an annual increment based on the Consumer Price Index for BC.

The BCMA proposes that these maximums may have to be increased to insure that they are not less than is now being paid under some existing contracts, including the CASC contracts that have been given to some highly qualified specialists in teaching hospitals. I understand the future of these contracts may be uncertain. They are probably the way of the future for our most highly qualified specialists, but details of these contracts are not known to us.

The Government proposes a much reduced salary scale ranging from $89,578 to $106,257 for general practitioners and from $108,912 to $125,022 for specialists plus funding to the Health Authorities for benefits and an allowance for overhead.

For service contracts, the Government proposes a scale of $159,500 for general practitioners, $151,600 for general practice in obstetrics and gynecology, and $180,000 for general practice in anesthesia. For specialists, the Government proposes a differential salary for 24 specialties, ranging from a low of $180,000 for nine specialties and a high of $329,900 for Neurosurgery. These numbers are said to be taken from Median FFS billings which, the BCMA points out, include non full-time practitioners The Government proposes a different rate for Pathologists

The Government says that it does not propose a decrease in the rate paid to service physicians but the BCMA points to markedly increased amounts paid in various specialties throughout the province.

I find the same general differences in the positions of the parties relating to sessional and rural payments. With respect, although these matters are included in Phase I, I do not believe that this Board is in any position to settle even the principles that should be applied in this exercise just on the basis of the excellent written

and oral submissions we received. These are detailed technical questions on which it is necessary to make comparisons. The BCMA proposes that the Board direct the parties to attempt to negotiate these matters but the Government says we should determine the principles before such negotiations are likely to be successful. I am not sure what the best course will be, and I recognize that the Government is entitled to have this matter determined in Phase I. In my view, however, the parties should attempt to negotiate settlements and perhaps what we have said on the question of FFS compensation will be some assistance. At the very least, I believe we must have a further hearing with the parties, before or after they have attempted negotiation, as they may think best. As the hearings were focused heavily on other matters, these detailed questions did not receive the attention they require in the proceedings to date, and I do not believe that we can do fairness to the parties without further assistance from counsel.

The answer to the second part of A(iii) is that we require the assistance of parties before we can provide a proper answer.

A (iv) Should physicians receive compensation for providing telephone advice to patients? For providing prescription renewals by telephone? And A (v), at what value?

I propose to answer these two questions together.

The BCMA submits physicians should receive compensation for these two services. On a FFS basis, physician's compensation is based on service at the prescribed tariff rate. It is obvious that the amount of time, skill and care required to give telephone advice to patients will be highly variable. While physicians have historically provided this service without charge, there is no reason why they, any more than other professionals should be expected to treat patients by telephone gratuitously. In this respect, I note the College of Physicians and Surgeons has required physicians to examine the patient's chart and to note all telephone advice. A physician who gives medical advice over the telephone risks legal liability for negligent advice. Dealing with a patient's problem over the telephone, of course, may make an office visit unnecessary.

There is, of course, a wide range of requests that might be received over the telephone. The matter may be a very serious one that should properly call for an office or hospital visit. If that occurs, the doctor should not charge for the call unless there has been a significant expenditure of time in which case it amounts to the equivalent of an office consultation. On the other hand, if there is significant time involvement, or the matter is resolved by telephone, then the usual or some lesser office fee would be warranted.

Calls about minor issues are very difficult to assess. Purely as a professional matter, some physicians may prefer not to charge for such matters, but a charge would be justified if such calls become a burden that interferes with a physician's practice or time for relaxation or recreation. One physician at Vanderhoof told me at mediation that he has received up to 35 such calls a day for which some compensation should certainly be expected.

This proceeding may not be the best way to establish a tariff for such items of medical service, but I cannot conclude that doctors should be expected to give free advice, particularly when they must

chart the call and possibly incur liability. But in the present circumstances of the Government, I think the charge should be nominal at least until the profession has some experience with these matters. I would direct compensation as a fee item of 50% of the charge for a “visit in office” under fee Code 00100.

With respect to renewing prescriptions, I understand the College requires a physician to look at the patient’s chart, and to note the renewal, and it is of course necessary for the physician to either write out a prescription, to ‘phone the pharmacist or answer the pharmacist’s call. While the chance of liability is not great for a repeat prescription, there is some risk and more so for other kinds of prescriptions. Again, there is no reason for the physician to do this without charge, particularly as it may avoid an office visit. As I believe prescription renewals are less onerous than telephone advice the former should be paid at the rate of 25% of the “visit in office” under fee Code 00100.

The BCMA has also asked if physicians should be allowed to charge for advice given to family members and other caregivers who

are not Health Care Workers. The question of whether information should be furnished to such persons may be a matter for the attention of the College. To the extent that physicians are entitled to give advice or prescriptions to such persons these services should be treated as if the patient had personally made the request.

Counsel has not asked us to deal with the question of telephone advice to Health Care Workers. This was described in mediation as a serious problem for some rural physicians who are the first line of inquiry for numerous Health Care Workers in their geographical area. I would regard such inquiries as the equivalent of a minor office visit for fee charging purposes.

BCMA concedes there are no similar charges in Alberta and that any payments made under this head should come out of the FFS budget. I do not know how to deal with this problem, and I would refer it to the parties for further negotiation and, if necessary, a further detailed submission for our assistance. The parties should agree on a reasonable number of chargeable calls each physician may bill per day for both telephone advice and prescription renewals.

The answer to this question A (iv) is 50% of "visit in office" (Code 00100), but subject to receiving further submissions from counsel before finalizing this matter. The same applies to question A (v) but the fee is 25% under the same code.

A(vi). Should physicians receive compensation for completing forms that are required by the Government or other public bodies. And A(vii), If the answer to (vi) is yes, what should be the value of such compensation?

There is no doubt that the required completion of some forms for the patient's benefit is a major irritant for many physicians, particularly the Special Authority Form required by Pharmacare when a physician prescribes some drugs where there may, arguably, be a suitable, less expensive alternative. The question that arises, of course, is whether the physician or Pharmacare should make that determination for the benefit of a specific patient for whom the physician has made a medical judgment. This is a major matter, as over 130,000 of these are submitted every year and most of them are approved anyway. The BCMA says that the use of this form saves the Plan $30 million a year. I am not sure how that arises. BCMA argues that the cost of preparing this form should be paid to the physician for his or her time at the rate or $40.35 for the first page and $10 for each subsequent page which is the rate paid for similar forms in Alberta, but adjusted for differences in overhead. Where the physician must

review the patient's chart, the fee would be $78.68 which is said to be the fee paid by the WCB for such services. BCMA says that for payments under $40 there is comparability with Alberta and payment should be additional to FFS. For larger payments there is no comparable payment in Alberta and funding should therefore come from FFS increased payments.

The special authority form is an obvious irritant to physicians who advise that there are some drugs that are so well established as the preferred choice for certain ailments that no special authority form should be required. This may explain the very high approval rate.

I am reluctant to make an award on this issue as I do not think it is ripe for decision. Clearly, a form should not be required if it is going to be approved in all but a few cases, and I understand that, at least in some cases, the patient takes the prescription to the pharmacist and has it filled. In some cases, it is only when the application is rejected that the pharmacist is expected to recover the cost from the patient.

I do not understand from the evidence precisely what is allowed for this kind of form in Alberta, and particularly whether there is any limit on

how many forms an Alberta physician may be paid the $40 mentioned in the evidence. The parties must confer on this question and brief us further.

With respect to other forms, BC physicians get paid for some forms, such as those required by ICBC and WCB, but not for others. Some are very easy to complete while others, such as a Death Certificate form, are most arduous when details must be obtained from the grieving survivors. This problem should have been resolved years ago, and I do not think we should express any opinion on it at this time, awaiting further word from the parties.

The answer to this question is that we require further information from the parties.

A(viii) and (ix) Should physicians receive compensation for the time spent performing non-clinical work, such as serving on committees and boards which are required by Medical Staff By-laws? And if the answer is "yes" what should be the value of such compensation?

BCMA agrees that Alberta physicians are not "uniformly" paid for this kind of non-clinical work but submit that, in principle, they should be paid for meeting with hospital personnel who are paid for their attendance. However, many physicians have arrangements for service or sessional

payments that bring them into hospitals anyway and it is difficult to make a proper comparison.

I am anxious that there should be a new kind relationship between the administration of hospitals and there are probably different classes of meetings where the physician should be paid, and other kinds of meetings that are a benefit to the doctors to attend in order to make sure the hospital operates as closely as possible to their expectations. I would opt for payment if I thought it would help but I am not yet persuaded it is necessary. Physicians must also contribute to the new relationship, and this may be an item that goes with hospital privileges and the desire of physicians to have a role in the management of the hospital.

The answer to Questions A(viii) and (ix) is that there should be payment to physicians for participating in some of the work of hospital committees but not others, and the parties should attempt to arrive at an agreement failing which we shall make a decision.

B. Payment for On Call / Availability / Doctor of the Day

Question B(I). To which BC physicians should on call / availability payments be made?
(2). How should on call /availability payments be made?
(3). What should be the value of on-call availability payments?

Payment for on call is the horse that left the barn some time ago because the Government has agreed to pay for on call services to many physicians throughout the province, and rightly so in my view. This is an issue that has caused and is still causing much hard feeling and it should be put to rest. The Government does not dispute this except as to how it should be implemented.

On call is a responsibility of doctors with hospital privileges or responsibilities who provide assistance on rotation both during the day, evenings and night time. It does not apply to doctors going to the hospital to attend to their own patients or patients for whom they are responsible. That is covered by FFS. What is involved is a stand-by fee for doctors on call who must respond quickly, day or night either by telephone or by attendance at a hospital to provide services to patients who do not have or cannot reach their own doctor. During their periods of responsibility on call physicians must be near a ‘phone, and near the hospital; they should not have a drink; and they must always be “available”. Thus, doctors on call must accommodate their days, evening and weekends to meet their on call

responsibilities, and this can be very disruptive to both their office practices and their personal lives. On call responsibilities often make it necessary for doctors to miss office appointments, or, after a busy night, their next day ‘s appointments if they have not had enough sleep.

Ideal practice dictates that doctors should not be on call for more that one day or one week in five, but whether a doctor is on duty or not depends in large measure on how many doctors are in a particular service. Some highly skilled specialists are on call as much as every day or every other day when there are only one or two of them, while rural doctors at locations where they are the only physician could be on call all the time.

The physicians of British Columbia have provided on call service without pay for many years as it was regarded as part of their hospital privileges. As the pace of modern life has quickened, however, and as many doctors have decided to give up privileges rather than endure on call, the burden has become increasingly greater on those with privileges, and doctors have believed for some

time that they should be paid for this service.

In my view there can be no valid answer to the doctor's claim. As already mentioned the Government has agreed to pay for on call services in a number of locations during the past two years. It is true that this concession was extracted from the Government by service withdrawals, starting in Prince George and Williams Lake in 2000, but spreading quickly to many other locations. In each case, except Lion's Gate Hospital in 2001 during mediation, the Government made peace by agreeing to pay varying amounts for on call services. It is too late to turn that clock back and the Government has not sought to do so.

I have no doubt that physicians providing on call services should be paid for providing this facility and the Government agreed at the start of mediation to make our award for on call retroactive to April 1, 2001.

BCMA proposes a single $20 an hour base rate for on call, but

with adjusted rates for increasingly inconvenient hours as follows:

Monday - Friday	0800 - 1700: $20/hr
Monday - Friday	1700 - 2300: $30/hr
Sat./Sun./Corp	0800 - 2300: $30/hr
Stat. Holiday	0800 - 0800: $40/hr
Monday – Sunday	2300 - 0800: $40/hr

All rates double where the physician is required to be On site during the period of the on call coverage.

It is significant that the BCMA does not propose a differential on call rate for specialists.

BCMA argues that these payments should be additional to FFS charged for services performed during an on call period, and that physicians who provide on call coverage under service, salary or sessional arrangements should be entitled to the same or equivalent payments. Under this proposal, on call would often be a stand-by fee. The BCMA has not claimed the maximum amounts now payable under some on call agreements that are now in place throughout the province.

The Government is already committed to paying $15.7 million for what it calls “availability” in 2001, and it proposes a single,

province-wide program, retroactive to April 2001, funded by a maximum of $49.2 million (plus the above $15.7 to which it is already committed) for a maximum payment of $66.6 million. This constitutes a cap for on call services, and there is no explanation in the Government's Brief what will happen if $66.6 million is not enough to provide adequate coverage throughout the province.

Government argues, correctly I believe, that most doctors are concerned about the current state of inconsistent availability payments and accordingly recommends a comprehensive, consistent provincial program, which would replace all present arrangements except that those already in place would continue to their expiry date, such as March 31, 2002 in Prince George.

Then, however, Government wishes to radically change the availability program by limiting coverage to call groups of 2 or more physicians who would agree to provide full, continuous coverage (often described as 24 X 7) to a specific hospital or facility. Thus, sole practitioners would not be eligible without associating with one or more other physicians. I have trouble understanding how this would

work in places separated by geography from other physicians. They might find themselves expected to provide service in various communities many miles apart. The Government Brief states at para. 7.83.1 and 7.84:

> For example, physicians presently working in a community by themselves would need to share call and provide cross-coverage with physicians in nearby communities, as designated by health authorities to qualify for payment under this program.
>
> Government proposes availability services be provided under explicit contracts between physicians and health authorities. Contracts would set out compensation in accordance with the provincial framework and identify availability service requirements, based on program guidelines and local service needs.

The tables accompanying this proposal show a general physician group would be paid an annual, global amount of $100,000 to provide continuous coverage; specialist groups would be paid variable rates for continuous coverage as follows:

Tier 1 – On site continuous coverage:	$125,000 p.a.
Tier 2 - Continuous coverage;	$100,000 p.a.
Tier 3 - Scheduled second call for emergency availability when first call is already engaged	$50,000 p.a.

Presumably, each coverage group, with the approval of the Health Authority, could be constituted by any number of physicians more than one, and I assume physicians not included in an approved call group would not forfeit hospital privileges. I am particularly concerned about the level of compensation and about the terms of the proposed contracts which are a contentious issue between the physicians and the Government. I am also concerned about how the Government scheme would work. $100,000 might be enough to cover an urban area, but I do not understand how many rural communities might have to be grouped together to justify such an amount, and how workload would be distributed.

With respect to compensation, the BCMA argues in its reply that the Government proposal translates to hourly rates of $11.41 for general practitioners and $14.27, $11.41 and $5.71 for specialists. I have no way of knowing if that is correct.

In my view, the form of on call payment should be reviewed by the parties in negotiation because I do not think it is ripe for decision. In the meantime, in order to make some progress, I would make an

interim award for on call for general practitioners at 75% of the rates suggested by the BCMA, retroactive, as agreed, to April 1, 2001.

The answer to answer Question B(i),(ii), and (iii) is stated in the text, and we would make an interim award for general practitioners, retroactive to April 1, 2001, at 75% of the rates suggested by the BCMA, subject to the following, and less any amounts already paid or payable under other arrangements until their expiry. See also the direction at the end of question B(iv).

B(iv) Should there be different levels of payment for on call/availability between;

- Physicians covered by the Rural Subsidiary Agreement and other physicians?
- Different specialties?
- Specialists and general practitioners?

Notwithstanding the BCMA position that there should be only one rate of compensation for on call, it submits that rural physicians should receive higher on call payments than other physicians. Again, I do not think this question is ready for decision because although I suspect rural physicians should usually receive more than general practitioners in urban centres, I suspect that some specialists should be paid as much or more than rural physicians. I remain to be

persuaded that specialists, as a rule, should not be paid more than general practitioners based on the proportionality that already exists between their regular incomes.

Again, to provide some immediate relief pending further negotiations, I would make an interim award that rural physicians (as defined by the parties) and specialists should receive payment for on call services at 100% of the rates suggested by the BCMA, retroactive to April 1, 2001. I leave for further consideration the question of differential on call rates, if any, between the different categories of specialists.

The answer to this question is that rural physicians and specialists should be paid 100% of the rates suggested by BCMA, retroactive to April 1, 2001, less any amounts already paid or payable under other arrangements until their expiry. This award and the previous award for on call payments are interim awards. These on call payments will apply to October 1, 2002. Before that date, the parties may negotiate a different arrangement possibly based on the experience of other provinces that have recently moved to a practice group on call payment system, eg. Alberta, Saskatchewan and Ontario. We will retain jurisdiction to deal with this matter further in the event the parties are unable to reach an agreement. These on call interim awards are additional to the interim FFS award made earlier in this Award.

B(v) Should there be payment for on call availability in circumstances where less than 24 hours/7days a week per year coverage is provided by a physician or group of physicians.

We heard about a situation where there were two physicians in Logan Lake. They provided 24 x 7 coverage with each doctor being on call every other day for which they each received $1500 per month. One of the doctors moved away, and the remaining physician said he would attempt to provide coverage every day if he received both stipends. The Health Authority refused, and arranged for physicians from Merit and Kamloops to provide as much coverage as possible that was less than 24 x 7. This, and other factors, led the remaining physician, who was already risking burnout from overwork, to move away leaving Logan Lake without a physician.

My view is that the Health Authorities must decide whether and how they will provide on call coverage for the hospitals in their charge. If the authority wants whatever coverage a single physician can provide then it should be free to make arrangements accordingly.

The answer to this question is that Health Authorities should not be precluded from making on call arrangements with single practitioners if it considers it prudent to do so.

B (vi) and (vii) Should physicians be compensated for providing "Doctor of the Day" coverage to a hospital.

Having regard to the views expressed with respect to on call, it would be inconsistent and illogical to conclude that "Doctors of the Day" should not receive reasonable compensation for such services.

The value of such services is very difficult to estimate because some hospitals may be much busier than others. This value should be negotiated. BCMA has furnished fees paid at a number of hospitals that vary between $750 per weekend day and $500 a day in Kelowna; $500 per day in Vancouver; $295 in Prince George; $250 at UBC; and up to $2,000 a day in Surrey. FFS charges are also permitted except in Surrey.

Again, I do not think this issue is ripe for decision. There should be negotiations on this issue. I would make an interim award

of $400 a day except in those locations where a higher rate is being paid, retroactive to April 1, 2001, and FFS charges should be paid as well.

The answer to this question is an interim award of $400 a day except in those locations where a higher rate is being paid under a different agreement (which should be continued until expiry), retroactive to April 1, 2001.

C. Administrative Contracts

i) Should physicians be required to sign binding individual service contracts in order to receive the benefits under the Working Agreement or subsidiary contracts?

The disputes over pro-rationing, RAD days and withdrawals of services over unpaid on call are visible low-points in the relationship between the physicians and Government. Government is particularly disappointed over service withdrawals during the term of a Master Agreement even though it is clear that neither party breached any contractual obligation. By the date of the Framework Memorandum, service withdrawals other than RAD days had not yet occurred but perhaps they had been threatened. In any event, Government in 2000 bargained for and obtained the agreement of the BCMA that it would not sponsor, support or condone withdrawals of service, and

would take all available steps to prevent such initiatives. In exchange, Government gave up the right to pro-ration fees without one year's notice in the event FFS fees threatened to exceed the budget. I am not sure this was much of a concession because RAD days were so unpopular that government was unlikely to pro-ration anyway.

Having bargained for the contractual protection just described, it is understandable that Government would be doubly disappointed at the widespread withdrawals of service because of on call in mid-2000 particularly when on call was an item for negotiation in earlier negotiations and it was an item that was expressly stood over to the mediation-arbitration in which we are engaged. It is argued that the physicians were entitled to be frustrated by the delay in the start of negotiations. As they did not commit a contract breach their conduct must be judged on a professional basis, which is a matter for the College and not for us.

When Government agreed to pay for on call services in Prince George, the horse was well and truly out of the barn, and it is not surprising that other communities would demand the same, as many

did, or that Government would also have to make settlements in those communities. The Government now admits what it did in Prince George was a mistake. Thus, to some extent, the difficulties in 2000 were caused at least in part by the political decision of the Government to give in to physicians withdrawing services in Prince George.

I have already mentioned the 2001 withdrawal of service by some of the physicians at Lion's Gate Hospital in North Vancouver. They, too, were so frustrated by unpaid on call and the failure of the hospital to establish an emergency service that would have limited on call and provided better access to hospital services for their patients. They also withdrew their services without the support of the BCMA. In their case, however, the government held firm about on call, but the hospital did take steps to solve the emergency operation room situation.

It must be stressed that the BCMA, like the withdrawing physicians, has not breached its covenant in any way. It urged the physicians withdrawing services not to do so, but feelings were

running so strongly that the withdrawals went ahead notwithstanding the contrary advice of the BCMA, and even, indeed, the views of the College of Physicians and Surgeons.

Thus, Government's concern about continuity of service really arises from the actions of a very few physicians. The great majority of BC physicians throughout the entire history of the province have never withdrawn service, and those few who did acted in response to what they regarded as unfair treatment. I doubt if there is any real risk that there will be future withdrawals of service if a better relationship can be established.

The Government's proposal changed between its original Brief and its Final Submission. The Government's statement of its final position begins on p. 47 of its Outline of Final Argument on Phase I. It is that the Working Agreement include provisions that would:

> …prohibit physicians from engaging <u>individually or in concert with other physicians,</u> in a withdrawal or withdrawals of services (including a refusal to accept expected duties at a hospital or other publicly administered health facility, or a resignation of hospital privileges) for the purpose of pressuring Government or its agents to change the terms and conditions of the Working

> Agreement, or any of the Subsidiary Agreements…

The proposal goes on to provide that physicians breaching the above provision would forego entitlement to Government contributions to benefits including the physicians' continuing medical education program, disability insurance, RRSP's, and the premiums for malpractice insurance.

With respect, I doubt if this is workable because only the BCMA, not individual physicians, are parties to the Working Agreement. Alternatively, however, the Government proposes:

> In the alternative, Government proposes that the Working Agreement contain language requiring that eligibility for contributions in respect of benefits is conditional upon individual physicians executing an administrative contract in which the physician: (a) agrees not to engage in service withdrawals; and (b) acknowledges that should the physician do so, the physician will forego any entitlement to contributions.

The government also proposes a clause to be negotiated by the BCMA and the Health Authorities establishing an expedited process to resolve local issues arising from service withdrawals. I take this to

be an effort to establish a mechanism for resolving questions such as whether there has been a withdrawal of service, and whether the conduct alleged amounts to a fundamental breach which the law requires before such a draconian remedy could be exercised. Presumably the Government intends a form of expedited arbitration by a neutral person.

It is noteworthy that these clauses are aimed at all physicians, not just those contracting with the Government for service, but the first proposal is limited to a prohibition against physicians who, acting in concert, resign hospital privileges or withdraw hospital or health facility services. In other words, it is not aimed at a physician who for other reasons wishes to take some time off, retire or restrict his or her practice. This recognizes that the law does not attempt to enforce contracts of personal service. It is not clear whether the alternate proposal (4.6.4) is intended to parallel the earlier clause 4.6.1. It purports to require each physician entitled to receive benefits to enter into an “administrative contract” that is much more severe and is triggered by any withdrawal of service but I assume that the same conditions would be required.

The common law crime of conspiracy and the common law tort of civil conspiracy, and penalty clauses have a fairly consistent history of failure in modern times. The first proposal comes very close to the tort of conspiracy except that it goes further and purports to authorize sanctions for doing what may be lawful, and it creates remedies against the activities of physicians acting in concert to refuse to provide a service they may think is not good medical practice which they could lawfully refuse to do on their own. Moreover, the ethical conduct of physicians is really a matter for the College of Physicians and Surgeons upon whose authority we should not intrude. The alternative comes closer to a penalty because the remedy may be wholly disproportionate to the alleged breach.

BCMA argues that no other province in Canada has attempted to impose clauses like these upon its physicians, that an independent Commission (Korbin, 2001) studied this problem and resiled from recommending remedies. The BCMA argued further that these benefits have been achieved through bargaining over several years and ought not lightly be limited .

While I understand the anxious concern of Government to insure continuity of service, the history of medical practice in this province, except for the last few months, does not support a need for such drastic remedies. The RAD days and recent withdrawals of service occurred in times of mistrust and severely strained relations that will hopefully be improved by the process in which we are engaged. To impose such clauses on the physicians would understandably be regarded as a sign of continuing mistrust and could make relations even worse than they have been.

The answer to this question is in the negative.

C(ii) Should there be some other method by which physicians should be prevented from withdrawing services. If so, what should that method be?

There are two answers to this question. The first is that the parties must commit themselves to work more closely together to improve both the quality and efficiency of the health system. It will not be helpful, and injustice may be done, for me to attempt to assign

blame for the deplorable relations between the Government and the profession. It may be that health dollars have not been spent wisely, or that they could have been spent more wisely. It may be that the government side has become overly bureaucratic or that the physicians have not responded as well as they might have to government's well intentioned, but possibly misdirected attempts to improve service to the public. There are many other possibilities and there is no profit in speculating.

What is clear is that there is much to be done. Once physicians are assured reasonable compensation, they must be prepared to cooperate with Government in its attempts to ensure that health dollars are well spent. But Government must enlist the assistance of the profession because little can be accomplished without its helpful cooperation. Again, I do not wish to point fingers, but many physicians do not think Government respects the contribution doctors make to keep the system functioning as well as it does. In this respect, we recognize that the quality of medical care provided by the physicians of this province is of a consistently high standard. The problem is delay for many of the non-emergent circumstances, and

delay is caused by shortages of physicians and facilities which in turn is caused by limited financial resources. Government understandably believes that nearly $10 billion should be enough. But it may not be enough to sustain this defining feature of Canadian nationhood in its present form. We hear much these days about reforming the medical health care system. Whatever Government decides, it will take some time, and whatever emerges will still be a defining feature of Canadian nationhood. This can only be achieved by Government and doctors, and many others, working together in an atmosphere of trust and co-operation. It must be remembered, however, that doctors are key players and they can probably contribute the most to make things much better, and to reduce or eliminate the risk of interruptions of service.

The other answer to this question will be the appointment of an independent person or group of persons who will provide on an ongoing basis a quick response to ensure that problems are solved, as they say in industry, on the shop floor, before difficult problems become major problems. For example, the unfairness of pro-rationing and unpaid on call for over-worked doctors should have been

recognized and solved a long time ago. The interaction between the profession, the Health Authorities and Government is enormously complex and diffuse. All sides think they know what needs to be done, but they have not been communicating very well. They need someone to remind them of the importance of what the other side is saying. If the Government starts to trust the doctors, the honour must certainly be returned.

The answer to this question is better cooperation and the establishment of a person or process as described above to improve relations between the profession, the Health Authorities and the Government.

D, Scope of Service, Sessional and Salary Agreements

i) Which group of physicians are covered by the Provincial Service, Salary and Sessional Agreements**?**

The problem on this question is to determine whether certain employed physicians are covered by and entitled to the benefits of the new Master Agreement and Framework Memorandum. Examples in dispute include Public Health Officers, Chief Operating Officers of Health Authorities, Vice Presidents of Medicine at hospitals, and other

physicians with major administrative roles, some of whom may provide clinical services as well as discharging administrative responsibilities.

The concession made by the Government in argument that Medical Health Officers are entitled to representation by the BCMA makes this question much easier than it would be without such concession. The same may be said for the concession of the BCMA that physicians employed by the Faculty of Medicine are not included.

While we were treated to very learned arguments on this question, I have no doubt that the proper response to this question is that physicians providing clinical service to patients (including Medical Health Officers) are covered by the Provincial Service, Salary and Sessional Agreements for such services. Physicians who do not provide clinical service but are employed in a wholly administrative capacity are not covered. With respect, I do not think it is necessary to say anything further about this question.

The answer to this question is that physicians who provide clinical services are covered with respect to such services by the Provincial Service, Salary and Sessional Agreements?

E. Term of the Agreement

1) What should be the term of the Working Agreement and subsidiary agreements?

The Government argues for a two and one-half year term from April 1, 2001, expiring September 30, 2003. The BCMA suggests three years from the same date, expiring April 1, 2004. I would have thought an even longer term would be better, to allow this matter to be completed - which may take a few more months - and then to give the parties time to restore the kind of mutual trust and confidence the medical system so urgently requires. On either term, the parties will be back negotiating the next contract within about a year of our final award. This is another matter where some discussion between the parties should be useful. If they cannot agree, then this Board will pronounce finally on the question.

Notwithstanding the views of the parties, I think the new Agreement should have more time to create a better relationship

between the parties. I think the Agreement should be for a term of four years from April 1, 2001 but I would not impose that date on the parties now although we retain jurisdiction to do so if not persuaded otherwise.

> **This question should not be answered at this time. The parties should confer, and that we should revisit the matter after they have done so.**

The above constitutes an interim award on Phase I. The parties must now attempt to resolve as many of these outstanding matters, and as much of the following Phases as they can, and we will continue the arbitration at the earliest possible date with a view to reaching a final Award as quickly as possible.

I wish to thank Mr. Harris and Mr. Berardino and their associates again for the highly professional way they have presented the positions of their clients. It is a difficult, complex matter, made much less difficult than would have been the case without their assistance.

Allan McEachern
Chair

I agree:

Dr. Charles Wright. M.D.
Member

I agree:

Dr. William Orovan M. D.
Member

Vancouver, B.C.

February , 2002

ADDENDUM

While it is not within the terms of our mandate to suggest a detailed allocation schedule for this award, my colleagues consider it necessary to comment on the current anomalies in the fee schedule. They tell me that at the time of Medicare's inception, a schedule of reasonable fees for all medical services provided by physicians was negotiated between the medical associations and the government of

each province as part of the legislated mandate to provide physicians with “reasonable compensation”. The current fee schedule is the result of applying multiple negotiated percentage increases with sometimes minimal regard for the major changes that have occurred in the practice of medicine due to advances in technology, medical knowledge and availability of services. These increases have usually been spread evenly across the fee schedule. New fee items have sometimes been added as required, but existing fees have not always been adjusted to account for changing practice patterns, service volumes, and resource utilization. It may be that the relative distribution of funds within all the items in the current fee schedule needs to be re-examined.

My colleagues tell me this problem s recognized by the medical profession and its associations, but attempts to make reasonable amendments have not always met with significant success. My colleagues are aware of the intensive work on this issue currently in progress in Ontario and Alberta. It is anticipated that the final report of the Ontario Resource-Based Relative Value Schedule Commission will be available this year. The Board recommends that the parties to

this arbitration process give careful consideration to these developments in this area.

Allan McEachern
Chair

I agree:

Dr. Charles Wright. M.D.
Member

I agree:

Dr. William Orovan M. D.
Member

Appendix" A"

Dr. A.

Dr. A graduated from UBC in 1976. He works with five associates in a full service general practice in Vancouver operating under FFS. He also did part-time emergency service at Mount St. Joseph Hospital from 1979 to 1992 working a 12 hour shift once a week. He and his associates provide 24 hour service, seven days a week, 52 weeks a year. He said:

> We offer the full range of services. Four of us do obstetrics. We do hospital-based work. We make house calls, palliative care. We do everything.

Dr. A said he has a large practice of close to 2000 patients. He explained that a primary care physician is a doctor who works for a Health Clinic, most of whom do not need or want to have hospital privileges. He added that both kinds of doctors are necessary because some members of the public want to have a facility they can walk into without an appointment and get some immediate attention. Full service physicians, on the other hand, provide care in an ongoing relationship with the patient. There are limits, however, on how many

patients can be seen in a day, the limit being 47 at the full rate. Physicians are paid 50% of the fee for seeing between 47 and 62 patients a day, and nothing is paid for seeing more than 62 patients in a day.

Dr. A. works Monday to Friday with four and a half days in the office and an evening shift on Monday nights, but often it's a question of whether he is gong to get home by 8:00 or 9:30 in the evening. His group includes three men and three women and two of the latter do not work full-time. His clinic divides each day into two sessions, morning and afternoon, and each of them works a minimum of six sessions to carry their share of the overhead. One of them does a session in the Geriatric Assessment Unit and another does a session at the Osteoporosis Clinic at the BC Woman's Hospital. He is on call at Woman's Hospital every fourth weekend because although they had 140 to 150 physicians on staff two to three years ago, there are only 73 now. The reason for this drop in numbers include the aging of the doctor group who no longer wish to do obstetrics and the decision of many young doctors not to get into that field.

When asked why he works nine sessions a week, he replied that he regards himself as a “dinosaur” because until recently roughly 50% of graduates physicians chose family practice as a lifetime discipline. That number has been steadily dropping and last year only 31% chose general practice. He said there are a number of reasons for this, but he added;

> I think when they look at the old dinosaur like myself and look at the hours I work and the commitment they think I’m crazy. There are other reasons. We have more and more women physicians going into family practice, and for all the legitimate reasons they don’t work at the same capacity. They can’t, the have other commitments, family commitments and so on. So there’s a variety of reasons why the younger docs -- - but I think one of the biggest reasons, at the end of the day they look at their income that they are going to earn as a family physician. And quite frankly, I think that’s a deterrent to many from going into family practice.

He also said that because of the decreasing numbers of full service physicians doing obstetrics, “…the net impact is that we’re into a crisis mode in the provision of obstetrical services.”

He described the difficulties of being Doctor of the Day that requires him to be on immediate call for a 24 hour shift. His experience is that he will be called to the hospital a minimum of once

or twice a day. This requires him to leave his office and drive immediately to the Women's and Children's Hospital to the annoyance and consternation of his in-office patients. As a result, he greatly reduces his office patient list for the days he is Doctor of the Day.

For Doctor of the Day service he gets no pay except what he can charge on FFS for whatever work he actually does at the hospital, but in many cases these kinds of patients have no medical coverage so it is free work. As a result, he says, many physicians are giving up hospital privileges so they will not be required to provide on call service. This came to a head at the Vancouver General Hospital a few years ago when the Department of Family Practice threatened to resign *en masse* because of this requirement. This resulted in the hospital agreeing to hire "hospitalists" (paid physicians who assume the Doctor of the Day responsibility) as part of the solution. But they only provide coverage during the day. At night employed physicians now look after this responsibility but they are paid $500 for each shift. He is required to be Doctor of the Day about one day every two months at the Women's and Children's Hospital. Some physicians

regret the absence of day-time contact with hospital life and association with specialists, but are anguished by the linkage between Doctor of the Day and admission privileges.

Dr. A explained that Doctor of the Day work is particularly stressful because he is dealing with strangers who are not his regular patients and they do not know him. He has to be extra careful to be sure he gets a complete history and to do a thorough examination because he is exposed to legal liability even though he is treating someone he knows nothing about. Besides, he says he is so busy looking after his own patients that he does not have time to be Doctor of the Day.

Dr A is not accepting any new patients in his practice nor are any of his associates except perhaps for a family member of an existing patient or when a specialist “leans” on them to take on a new patient. He said that he knows of practically no physicians except new, young doctors, who are taking on new patients. Even the young ones soon become so busy that they cannot take new patients.

Dr. A said he spends about 30 to 40 minutes a day filling out forms for some of which he receives no remuneration. Others are paid for by agencies such as the Workers Compensation Board and the Insurance Corporation.

Dr. A said his office receives from 10 to 15 telephone calls a day from his patients seeking advice. Some of these can be handled by his staff, but he personally has to field about five to seven such calls a day which range from five to fifteen minutes each for which he receives no remuneration. He also said he receives from five to ten requests a day for prescription renewals either from a patient or from a pharmacist even though he thinks it is not good medical practice to prescribe over the ‘phone. This necessitates pulling the file to check the current situation and he estimates the average time requirement at about seven or eight minutes for each of them. He receives no remuneration for this service.

Dr. A said that it is almost impossible to find a *locum* at the present time. This means he cannot take time off without adding

additional burdens on his associates, and, of course, time off without a *locum* means the overhead continues without any revenue.

Dr. A said:

A Well, my wife and I sit around and talk about this quite often, looking at where we were ten to 15 years ago, and where we are now financially. I would say that in a nutshell that I am working probably almost twice as hard as I was ten to 15 years ago, seeing somewhere between one and a half to two times as many patients, and at the end of the day my disposable income is probably less than it was ten to 15 years ago.

Dr. B

Dr. B is an anesthesiologist who began his specialist practice in Victoria BC in 1977 after first starting practice in Eastern Ontario. When he arrived in Victoria there were two anesthesiologists and over the next few years he helped transform the section into a modern department. Between 1982 and 1984 the two Victoria hospitals were merged and he became the first chair of the combined department. He continued in this responsibility until 1992. In 2000, he moved his practice to Lethbridge, Alberta.. He described the reasons for his move:

I found it impacting a lot of the way I wanted to practice medicine. We would be held responsible, it seemed to myself and to my colleagues who we—we talk a lot in the coffee room and in the lounges. We were held responsible for a lot of the ills with healthcare. If there were over utilization, it was usually because of the doctors. If there was underutilization with long waiting lists, we were held accountable. If we tried to reduce the waiting lists by doing more surgery, that was over utilization.

We never seemed to get credit for the things we did well. The morale of the doctors including the morale of my own practice and my own self-esteem, you could see it deteriorating on a daily basis. I started thinking in the late 1990s of an alternative.

Q Did the claw backs at that time have an impact on that level of frustration?

A There had been claw backs before 1999 which we had more or less put up with. In 1999 the claw backs were, I felt, excessive. As an anesthesiologist it was more excessive. We were one of the heavily claw backed - -

Q The claw backs were a result of prorationing?

A Yes. The claw backs were - -. I've never been on committees at a provincial level. To my knowledge, it was because of a capped budget…

I looked at it. In my specialty, it was approximately a 7 percent claw back off the top of your income. I looked at it as a surtax on healthcare on doctors of the province. I did not think that was fair. During that time I actively started looking for work elsewhere.

Q Were the problems that you described particularly worrisome for a physician moving towards the end of his career?

A I'm about 56 hears old right now. I still have a good nine or ten years to work. Retirement planning is something we're supposed to start early. Some of us don't start as early as we should. Most of my retirement planning was being put on the

> back burner while I was in Victoria because of confrontations with things like the claw backs and also within the local hospital system. We were having hospital closures in Victoria as much as six weeks a year. At Jubilee Hospital we would go from 12 rooms down to 4 rooms during those weeks. You're working about one-third time during that time. Those closures and claw backs impacted incredibly on our incomes. The planning that you plan at age 40 was no longer there. Instead of retiring at age 60, you're ever moving into 61, 62 and 63. These claw backs and closures were significant in our decision to move.

He said the final straw was the announced closure of a 52 bed pediatric intensive care unit that included a pediatric ICU that he had worked hard to establish and to recruit physicians with special skills. Actually, the unit did not close, but he said he was so fed up with bluffs about closing this and that and he never knew if he would be working the next day or not. He said such a decision should never have been announced without consultation with the profession.

He went to Alberta because a friend practicing there asked him to cover for him temporarily. When he went there he found a totally different attitude towards physicians and a difference in income as well. When the present agreement is implemented he will have a 50% increase in income for the same hours worked.

He said in the 12 months period immediately before he left Victoria there were 12 specialists who left before him, some for Alberta and some for exotic places in the Far East, Abu Dhabi and Saudi Arabia.

He said the decision to leave Victoria was a very difficult one because his parents live in Sydney, and he is a sailor who has done a lot of racing and cruising including both off shore and coastal sailing. He owns a home and sail boat that he has kept in Victoria because some day he expects to return there.

In Lethbridge four of the ten anesthesiologists are from B.C., one from Cranbrook who left there because his operating room time was reduced to two days a week and he could not make a living. Another one, “the young epitome of what a department wants to build on” attended Dr. B’s going away party and when he learned why Dr. B. was leaving he decided to go too.

Dr. B says he worked harder in Victoria and the increased income in Alberta permits him to work fewer hours so that he can

take reasonable time off, and have a better life. He said that recruiting physicians for Victoria used to be as simple as a phone call. In 1990 they wished to enlarge their department so they advertised in national journals and they received 40 applicants that they pared down to the two they actually hired. At that time the fee schedule was quite attractive and competitive with other provinces. When he left Victoria there was only one applicant but the position was not filled because of uncertainty. He said other specialists are leaving Victoria. He said:

> Currently there is an anesthesiologist leaving for Portland, Oregon from the Victoria General Hospital. Her husband is an orthopedic surgeon. Another is leaving, a cardiac anesthetist. He's leaving shortly. One fellow who is the same age as me is retiring fully in April of this coming year and three of my close friends in Victoria have set their retirement date for two years right from now.
>
> I see an exodus from that department in the next 24 months. It's going to leave quite a shortage. In anesthesia in this country there's a shortage. There are 250 posted vacancies in anesthesiology, so it's an extremely competitive environment for people looking for work.

He also said that Victoria life-style is not enough to attract physicians to Victoria as it once was. He described how he responded to a political initiative in the last election to write to the government explaining why he had left the province. He received a

reply saying that the new government wanted to make the province a “magnet” to attract people like him back to B.C., but he said no one will leave Alberta to take a pay cut in B.C.

He explained that before he left he was working 60 hours a week but with ten anesthetists, the departure of one increases the work load of the others by 10% or waiting lists get longer, and he mentioned again that four more are leaving in the near future. He said that within the last two weeks, he has received inquiries from four B.C. doctors some of whom are interested in doing *locums* in Alberta because they expect further slow-downs and shut downs in B.C.

In cross-examination, Dr. B agreed his group in Victoria has been discussing an alternative payment plan that was first rejected but then accepted and that there is now a possibility of an APP for anesthetists but all such plans are on hold awaiting the outcome of this arbitration.

Another problem Dr. B discussed was the cancellation of operations because of congestion in the hospitals caused by the necessity of dealing with emergency cases. He said that "cancer would go before pain" and access was an issue for him and others leaving Victoria. He said an assurance that he could practice without cancellations, and "equity with his current base …" would probably bring him back to B.C. He also mentioned that threatened hospital closures of up to six weeks a year in B.C. because of funding problems are a difficulty for physicians.

Dr. B said he believed this mediation-arbitration process gave him some hope for the future, that he was honoured, "as one of the guys in the ranks doing the work" to have a chance to express his opinion, and he added:

> I would like to see a fair, negotiated settlement. If there's a degree of fairness, as I stated earlier, I would certainly be interested in returning to British Columbia. As I stated, my parents are here, my friends are here… It's not a problem in BC alone; it's a problem nationwide. On the airplane flying here yesterday, I was reading in *The Economist*, for example. It's a problem in Britain. Ontario is advertising in their journals trying to attract Alberta doctors. It's a nationwide issue. I think if British Columbia is going to win in this, first off with the access

> to the operating rooms, I believe that will happen. I hope that happens in this province. People need access.
>
> In the interim, we have to have doctors to fill those voids when we finally get access. We're seeing doctors leaving the province. I've got four in my own department.

The doctor was asked about the general economy and attitude in Alberta. He said there is an attitude in Alberta that success is possible that is lacking in B.C. In addition, of course, there is no sales tax and other taxes have been lower until recently when B.C. reduced its income tax rate. He said that if things improve here, he and others would return. He added that anesthesiology is a "have not" specialty in B.C., but it is near the middle of the specialists range of fees in Alberta, and it is also a simpler, fixed fee schedule for each procedure instead of the eleven degrees of difficulty in B.C.

I should be mentioned that anesthesiology is indeed at the low end of specialist remuneration in B.C., as can be seen in Mr. Aikman's Table in Appendix A.

Dr. C.

Dr. C. is an internist with a specialty interest in cardiology. He graduated from medical school in 1966, and he has practiced in Salmon Arm since 1980. He was the only internist there for 12 years but there are three there now. He has been Chief of Staff for eight years, and the regional medical director of the North Okanagan Regional District until last April. He gave this evidence:

Q Describe the number of specialists recently lost in your region.

A There has been a particular shortage in radiology and general surgery. Radiology in Salmon Arm had a department of two which actually covered radiology in Enderby, Armstrong, Revelstoke and Salmon Arm. They did quite a bit of traveling. And in general surgery there's been a significant shortage in Vernon which has caused disruption and work stoppage.

Q You are down to three general surgeons in Vernon now?

A That's right. At one point there had been five. There are now three.

Q Was there a surgeon doing thoracic and vascular surgery who recently left in Vernon?

A The only surgeon who did thoracic work and vascular, basically the biggest need was acute aneurisms. He was also the

surgeon who did permanent pacemaker implants for the whole region. He left. He went to Abu Dhabi.

Q Have you been able to recruit a replacement for that surgeon?

A No.

Chairman: When did he leave?

Witness: He left in June.

Q Staying with Vernon for a moment longer, are you also recruiting or attempting to recruit a second cardiovascular surgeon for Vernon?

A A cardiologist.

Q I'm sorry, a cardiologist.

A There was an attempt to recruit a second cardiologist because of a much expanded workload. One was recruited. He came for the summer for a locum. It was a particular advantage for Vernon. There was an acute need for pediatric. He was a cardiologist and his wife was a pediatric. After doing a locum for a couple of weeks in July, they decided not to come. (to Vernon)

Because of the shortage of physicians in Vernon, Dr. C travels the 60 Km to that center three to four days a week and the specialists in Salmon Arm have to travel to Revelstoke about 12 times a month

He described the shortage of pediatricians. He said they are down to one and a half trying to cover the entire region because there

are no other specialists in that discipline except in Vernon. One of them is a new mother working part time and the other is retiring next year. Also, Vernon, a city of 60,000 does not have a general surgeon. There is a shortage of one Radiologist in Salmon Arm, and the department of four radiologists in Vernon is down to three because of the possibly permanent illness of one of them. There used to be seven internists in Vernon, but there are now only five with the expectation that it will soon be down to three. One left for Nanaimo, one for Kelowna, and two are negotiating with Alberta. Salmon Arm had three psychiatrists, and it is now down to one; it had two radiologists and they are down to one. He, also, proposes to retire next year but it has not been possible to find a replacement so he expects he will have to continue to practice at least part time after retirement in order to serve the community.

Dr. C described the principal difficulties of practice in his region as the lack of access and staffing and on call responsibilities. He mentioned that Salmon Arm is in the center of the Shuswap District that is a very busy recreational area in the summer, traversed, of course, by the Trans Canada Highway where many serious accidents occur, so it is a major trauma center and a very busy place.

Because of physician shortages in Vernon, particularly in orthopedics and intensive care, there is no place to send serious cases so they must be accommodated in Salmon Arm creating a heavy nighttime workload for their small operating room. When asked the cause of physician shortages, Dr. C said:

A There's a national shortage for specialists. I think at the present time there's 130 practices in radiology that are open and unfilled in Canada. There's a particular problem in trying to recruit to rural communities. In order to maintain a level of care in a lot of communities that can only staff two, three, four specialists, the obligation for night and weekend call is huge. And it used to be that we expected the beauty of the environment and the lifestyle would be enough to recruit. That's not enough anymore.

With regard to the morale of physicians in his region, he said:

Q Would you comment, please, on the morale of physicians that you work with?

A I have been there for 21 years. I know most of the physicians in the region. I've never seen the morale at a lower point. Again, that's multifaceted. I think it's overwork, it's ageing, it's conflict and confrontation, it's bad relationships. I think a very cynical attitude has crept into the whole profession.

Q Just focusing on the on-call issue for a moment.

A Yes.

Q What is your call schedule?

A For 12 years I was available as much as I could be. Obviously it wasn't 7 x 24. I got sick, I went to educational programs, I took vacation. But when you were there, you were basically on call. At the present time with the three of us there and some assistance from two of the anesthetists who are trained in critical care, it's about one in four.

Q Can you describe the effects of on-call in your experience on your personal life?

A Too bad we didn't have my wife here to comment on this as well.

With regard to on call, he said:

A I would say that it has been a significant impact. It's interrupted a lot of functions. It's changed a lot of plans on very short notice. I would estimate that over a 12-hour period from 7:00 p.m. to 7:00 a.m. there would be three or four phone calls and one or more trips to the hospital during that period of time.

The real problem for me personally is that is much more difficult with advancing age. I'm not sure of the explanation for that. Maybe it's dealing with my own mortality. I don't get called for rashes and ear aches. I get called for acute, critical issues. I think that the anticipation of the call is as onerous as the call itself so that you're waiting for the phone to ring.

Q What about impact on your office attendances the day after?

A Because of the variability of the workload at night, it's impossible to assume that there's going to be a lot of work at

night and you'll just cancel the next day in the office. Most of us find that we have to schedule Monday to Friday on a regular basis. If you're on call on a particularly onerous night, then you really can't cancel the day's activities at 7:00 a.m. so that you continue to run through the day, through the night, and through the next day.

Q How often does the phone ring on an average on-call evening at night?

A After hours?

Q Yes.

A After I've gone to bed?

Q Yes.

A Three or four times.

Q Of those three of four calls, how often do you have to attend hospital?

A At least once or five times. I would say that would be the range.

He added that Salmon Arm is now one of the communities that receives rural on call payments which he says are inadequate. But nearby Vernon (60 Km) is regarded as an urban center that does not receive such payments, causing tension with the doctors there. He added that his spending power over the years has diminished.

Dr. C. expects serious difficulties recruiting specialists in rural areas. Now, he says, they are just shifting them around with some coming to the Okanagan from the North but even then, they cannot replace all who leave. He added that:

A In my own community, with my retirement coming in the next year, I have commitment from one of the other internists to stay for one year and then he'll reassess. I do know that in Vernon two orthopaedic surgeons, one of the remaining three general surgeons and the only ENT surgeon are presently in negotiation with communities in Alberta.

Q Taking the two internists that you're working with, how old are they please?

A Thirty-nine and 34.

Q What are their plans? I know you've touched on one. With a little more specific reference, what are their plans?

A The 39-year-old has committed to one year. He has looked at other provinces. The 34-year-old has had negotiations with larger centers where the on-call burden is less.

Q This is, I think, an appropriate question to ask. You with your plans to retire will provide some coverage and then retire. Let me see if I can put this question to you. I wrote it all down here.

In your view, what will happen in your region if physician compensation is not improved substantially as a result of this arbitration?

A Well, the outcome, I can see it happening already. This is not a kind of futuristic point of view. It is happening that the ability to provide specialist care at a secondary and lower tertiary level is

> shrinking outside of the Lower Mainland. That's only going to increase.

In Cross-examination, Dr. C. described the difficulties caused by doctors in Vernon refusing to take unpaid on call responsibilities while physicians in Salmon Arm were being paid for this service. The result is that patients have to be transferred to Salmon Arm for treatment causing extra work there. Later, when the Vernon physicians were offered on call payment it was less than was being paid in Prince George so they refused to accept it.

The doctor described facilities in Enderby and Armstrong as adequate for the kind of services provided there, but all serious cases are referred to Vernon or Salmon Arm where facilities are not adequate as a referral centre.

Dr. C. was asked about the commitment of younger physicians. He said:

> Q Do you notice a significant difference in the attitude of the 39 and 34-year-old physicians that work with you in the way you have worked over your practice?

A Attitude and relationship, yes. I wouldn't place it all in the doctors' field.

Q I wouldn't at all limit it to the doctors' field. I'm asking about doctors. Do you find that the sociology of the new physicians is different in that they don't intend to do what you've done in your career necessarily?

A I would say that's true, but I would say that that's a cultural phenomenon. I would say that you see the same thing even in lawyers.

Q Yes. I do see the same thing in lawyers, yes. But the difficulty is in the law profession as well as in the medical profession is the question of how do you encourage younger professionals to take on the commitments that you've carried in the past or do they see themselves differently? Do they see that they have a contractual relationship with their job as compared to a duty relationship to their job.

Do you see that difference?

A I don't think so. I think perhaps their expectations are different, but I think that those physicians that I personally work with, I think there is a huge professional commitment that's still there. I don't think it's significantly varied.

Q Where do you see the difference, then, between physicians of your age and physicians in their 30's, if you could?

A Well, I think the two points that I would like to comment on is that I think that most physicians nowadays do expect to have a life as well as their profession which you could say that that is a difference in professional commitment. But I think it's probably much more realistic in terms of survival. As you probably know, physicians have had the highest rate of divorce, the highest rate of chemical dependency of any profession in North America. I think that physicians are saying that this 70 hours a week is unhealthy and we need to change that. That's one thing.

I think that the degree of cynicism has grown in the physicians in my lifetime which pretty much corresponds to the development of Medicare. I remember as a resident when that came in in Manitoba. I think that cynicism has taken a huge toll.

Q This is a long-term trend?

A Progressive.

Q But it has its origins as early as the mid ‘60s?

A I think 1968 was the introduction.

Q Do you have anything you could tell us that would be the solution as how you would balance out the life of these younger physicians and to encourage them to be enthusiastic about their profession?

A I don’t. I am nevertheless hopeful I’m not that cynical myself. But to give you something concrete about what I think we could do, I think providing them with the resources to do their job, to not blame them for demands on the system, to adequately compensate them, and to have a shared responsibility with a healthy working relationship would go a great distance.

Q So that improvement of the healthcare system and its management would be useful. Do you see that some of these younger physicians have more interest in contractual alternate types of work arrangements than would have formerly been of interest when you started?

A That’s a phenomenon of which I’m aware. I think that the profession and the government that their relationship is evolving. Twenty years ago, if you and I had a public conversation about contractual agreements, I would be burnt at the stake. Sixty percent of American doctors are on a contract, not a fee for service agreement. This is not just a Canadian phenomenon.

Q It's acceptable for members of BCMA to talk about alternate payments?

A And my wife was a contract physician until she retired.

Q She worked under a contractual arrangement with the hospital?

A With the region. Geriatrics.

Q That was useful for her in the way she wanted to work?

A Yes. And, you know, there are some particular areas of medicine where fee for service will not work, geriatrics being one of them where an office visit might last three hours. If the compensation was $30, that would be inappropriate.

Q You said that the problem was multifaceted; it has to do with overwork, conflict, bad relationships. Your answer is there needs to be a variety of solutions found to this problem and that professional income is only one of those issues?

A Yes.

In re-examination, Dr. C gave this evidence:

Q You were asked a number of questions about the Vernon on-call situation. Am I correct to say that the government's settlement with the Prince George specialist group on on call had a detrimental effect and was a fundamental cause of the unhappiness at Vernon with respect to on call?

A That was the gold standard that they demanded be met, $40 an hour on call. If on call is worth $40 in Prince George, then, damn it, it's worth $40 an hour in Vernon.

Dr. D.

Dr. D graduated from the Faculty of Medicine at UBC in 1992, interned at Edmonton, and opened a full service family practice (except obstetrics) in Victoria in 1993. He is not able to accept new patients. He has two partners in practice, one of whom, a recent graduate, is able to take on new patients. Dr. D said there are 20,000 patients in Victoria who do not have a family doctor and that many patients who attend at walk in clinics have serious health problems like diabetes, pain control for cancer and heart disease, who should have a continuing physician taking care of their longitudinal problems. His office receives from 5 to 10 calls a day asking if he can see new patients.

He said it is extremely difficult to find a *locum* in Victoria for purposes of a holiday as they are all booked six to nine months in advance, and a year or more for obstetrics. Because of this difficulty, his partners cover for each other. This creates ten hour days plus paper work.

He is assigned Doctor of the day for 24 hours once every two months and he finds he has to take over the care of about 50% of the patients he sees during his shifts. One of the difficulties he experiences is that all lab and other reports generated during his shift are sent to him, and he has to make sure they are passed along to the patients own physician if there is one, or otherwise follow them up with the patient himself which is often very difficult. There is no pay for being Doctor of the Day.

He said there has been considerable agitation about the burdens of Doctor of the Day, but negotiations were put on hold when this arbitration was arranged and all doctors are "waiting with bated breath" to see if funding will be available, and all doctors agreed to continue participating for the time being. He said it is very frustrating for the doctors to know that Doctors of the Day are compensated in some communities but not in others. He said, "…if [doctors] don't receive payment they will opt out of doing Doctor of the Day. In fact, they will opt out of taking on hospital privileges."

Dr. D. discussed filling out forms, some of which are paid for and some are not. He particularly mentioned a form relating to sexually transmitted disease that he says requires consulting his chart, and other processes that can take up to half an hour for which there is no payment.

He also explained the special authorization form for some kinds of drugs. This is a Ministry initiative to encourage the use of the most inexpensive drugs but when a patient does not tolerate such drugs a special authorization is required that takes 5 to 7 minutes to complete. He said the Ministry Web Site reports that these forms save $30 million a year even though 130,000 or 160,000 requests were approved last year. He also mentioned the difficulties of filling out birth and death certificate forms that are time consuming, often for the latter, requiring calls to coroners offices. Apparently doctors can bill patients for this form, but few do so. He also explained an inconsistency between the Therapeutic Diet Form which is not paid for and the similar Monthly Nutritional Supplements for which $25 is paid even though both forms do the same thing.

A particularly difficult form is the “Do Not Resuscitate” form. This is used when it is expected a patient will die, and requires the physician to consult with grieving families in order to get authority to give instructions, in proper cases, not to resuscitate the patient. Nothing is paid for this form.

Dr. D says he receives from 3 to 5 phone calls a day for medical advice that may take five to ten or more minutes each. He regards this as very risky because of potential liability. He has the same problem with prescription renewals which vary from 4 to 6 a day. Increasingly, he is getting requests for renewals by fax message.

In cross examination, Dr. D said that Victoria has more general practitioners per capita than many other areas in Canada. He agreed that there used to be 150 practitioners who did obstetrics in Victoria but the number is now down to about 40. He was asked why this is so and he replied:

A I think that there are multiple reasons. I think that remuneration is one reason. I think that if one looks at the trend for

withdrawal of obstetrical privileges, there is an association with the introduction of midwifery and the remuneration which midwives receive which is between two and two and half times as much for a course of pregnancy than a general practitioner would receive.

There are lifestyle issues as well. More and more physicians choose to be home for their kids. Part of the reason I chose to give it up was not only remuneration, I have two-and-a-half-year-old twins. I want to make sure that I'm around and that I don't have two families to support in the future and things like that. There is a lifestyle issue.

Q you look remarkably well for having two-and-a-half-year-old twins.

A I slept at Dr. Lawrence's last night and I got a night's sleep. Thank you.

Q you are one of the physicians who is not, therefore, maintaining obstetric practice?

A Correct.

Q In your group of four physicians, do you have other physicians who are prepared to care for mothers during their pregnancy?

A Nobody in our practice of four does obstetrical practices any longer.

Q These are the decisions of individual physicians as compared to any decision based on an authority?

A That's correct.

Dr. D also agreed that working in partnership [with the Ministry] would be a significant advancement in the delivery of health care to patients.

He was asked how payment for filling in forms would help physicians if, as stated by BCMA, the payment for forms not paid for in Alberta, and it has to come from the proposed general fee increase. He replied:

A One of our responses is to look at how we can actually keep general practitioners practicing full service practice and delivering the kind of care that you alluded to with respect to diabetics, cancer patients and other patients with chronic health problems. More and more general practitioners are also opting for changes in lifestyle, changes in patterns of practice. For instance, going into hospitalist positions and so on, leaving the province altogether because of some of the difficulties with respect to remuneration and increase in workload especially for this type of work with respect to forms and the requirement for general practitioners to justify accessibility to various services provided by government to patients.

The vast majority of physicians who fill out these forms are physicians in full service practice. It's unlikely that physicians practicing in limited scope practices would be doing forms. This is one way of differentiating those physicians who are practicing full service practice. I think it's another way of targeting fees to those positions. We're providing the kind of care, longitudinal care, that is desired by government, by patients and by ourselves.

It was pointed out to Dr. D that many of the forms physicians fill out are required by agencies other than the Ministry of Health. He was not aware of any requests being made by physicians for payment by those agencies.

In re-examination, Dr. D was asked about his evidence about doctors giving up obstetrics at the time mid-wives began to be paid by the Ministry. He said:

Q You were asked about GPs not doing obstetrics.

A Yes.

Q Did that have anything to do with the relationship between the payment to midwives as compared to the payment to GPs for this type of work?

A As I mentioned before, if you look at the rate of attrition of physicians doing obstetrics and the association with the introduction of midwives and their payment scheme, there is a direct correlation between the two. There is an extreme degree of resentment with respect to the differences in how physicians and midwives are paid.

Q And am I correct to say, without getting into all the detail, that midwives are paid substantially more than GPs for essentially the same services?

A They are paid approximately $2,200 for a course of pregnancy and are not capable of providing the comprehensive care that is

provided by a general practitioner who receives approximately $900 for the same course of pregnancy.

Dr. E

Dr. E received his medical training in Australia in 1979 and became a specialist in anesthesia in 1986. He has two sub-specialties in adult critical care and one in pediatric critical care. He came here from Australia in 1992. Since 1994 he has been in a salaried position in the Children's component at the Children's and Women's Hospital in the departments of pediatrics and anesthesia. He is also a clinical professor at the UBC Faculty of Medicine. This hospital is the major referral center for pediatric patients in B.C.

His primary responsibility is clinical care for the sickest of the sick children. He also has teaching, research and administrative responsibilities. His hospital is the second largest and second busiest pediatric critical care center in Canada with over 1,000 admissions and the only one in the province that has teaching capability in its special areas. They have students from all over Canada. Children's Hospital is the first pediatric training program in Canada approved by the Royal College of Physicians and Surgeons.

He has teaching rounds every morning, and as director of student's programs, he spends a half an academic day a week. His students include future specialists, outreach to other provincial hospitals, pediatric residents and he participates in other CMA programs. Because of his ever-increasing clinical workload he is only able to do limited research. There are approximately 90 salaried physicians at The Children and Woman's Hospital representing about 1/3 of all contract physicians in the province.

He said there are current and looming vacancies on the horizon that will impact critically on future service. He said there are now three vacancies and this contributes to the inability of the staff to provide adequate academic training and research because clinical care always comes first. There has been a shortage of four obstetric anesthetists for the last three years; two perinatologists, two pediatric radiologists, and future losses include those that are going to occur through natural retirement and losses that may result from the outcome of this arbitration. For example, two of the kidney specialists are now due for retirement. They are very hard to replace as the hospital has been advertising for a new director in that area since the

start of 2001 without any bites at all. Also, he said the British Columbia Department of Pediatric Radiology is the best department in the country and three of its members “will almost certainly go to greener pastures if arbitration does not produce some favourable outcome”. Two of them have been offered directors’ positions in Toronto, and Alberta is hunting for at least one of them. He believes their incomes could be doubled elsewhere. He added that the department of neonatology is short as they lost a doctor he called the brightest neurotologist in the country in July of this year. He went back to Boston where he was recruited from, and pediatric neurosurgery lost a member to Salt Lake City, both because of compensation and a lack of time for research. Doug Wilson, head of perinatology left for Philadelphia this year and he has not been replaced.

The projected needs of the department of pediatrics is 30 to 40 pediatricians which, he says, it is going to be impossible to recruit because compensation is clearly inadequate. He said there has always been a compensation differential between pediatric sub specialists and adult sub specialists, but even then, there are not that

many specialists out there even if there was a competitive compensation package.

Dr. E said that 85% of B.C. physicians do not have access problems because they have too much clinical workload in their offices. The same is true for pediatrics because critically ill children get the OR when they need it.

He said that the increasing clinical work load makes it necessary to do teaching and research after hours and on weekends, and ongoing shortages of staff with burnout, and people leaving or threatening to leave has caused demoralization. He said that stress is a real problem. When he came here he replaced doctors who were on extended leave for stress. He said most of the kids who die in his hospital die in ICU and physicians have to deal not just with the dying child, but also with an aggrieved family.

He said that with just a few more shortages, such as a cardiac surgeon, they would lose their cardiology program and we wouldn't have a referral center for the province. He said: "if you want to send

everyone to Alberta, that's fine, too. But it's not really what British Columbia needs..."

Dr. E. said he works 45 to 50 hours a week when he is on clinical service. When he is on clinical duty in the ICU he averages between 80 and 90 hours a week.

He has two separate call schedules. First, for the general ICU work, and second for the portable lung machine, usually following surgery which requires continuous bedside management. They share that with neonatologists, so the number of nights he works is about one in three and a half. They were not paid for on call until recently when the hospital agreed to pay the same amount as the adult critical care physicians.

His top range salary is $174,000 annually plus benefits, plus other amounts I will mention in a moment. He said this salary that was fixed in 1991 or 1992 is not a competitive salary. He went on to explain that the surgeons and anesthetists at Children's recently signed a CASC agreement that pays children's anesthetists

$300,000, adult anesthetists $325, cardiac specialists $475, and pediatric neurosurgeon $450. He said senior general surgeons are paid close to $450. He said these salaries have helped retention and recruitment at Children's hospital and that these salaries were fixed by comparison with salaries paid in Alberta. He said that under the Government proposal in this arbitration his salary would be an insulting $125,000.

Turning to Dr. E's other benefits, since April 2001, he has been paid an additional $500 when working at night which, in December, 2001, would be eight nights for an additional $4000 (about $62.50 for an eight hour shift). Usually this would be five to six nights a month, and might amount to $30,000 a year. He is also paid FFS for night service for which he received $65,000 in 2000. He is also paid an additional $900 for a few 13 hour shifts ($69.23 an hour) of anesthesia bedside services for which he might earn up to $12,000 a year so his total remuneration might be as much as $285,000 annually but for some very long hours.

There have been some recent additions to the hospital staff: a pediatric general surgeon from Stanford University; a neurosurgeon from Alberta; an anesthesiologist from Britain; two perinatologists from Montreal. No particulars were given about these new recruits or why they came here.

With respect to pay for on call services actually provided for which pay is available under FFS, the doctor said that when a “kid is crashing” it usually requires continuous bed side care, and if he sits beside the patient for eight hours, he only gets paid for two hours.

Dr. E said he would prefer to be paid properly under contract without having to resort to FFS for extra remuneration because in critical care the doctor has to be continuously by the bedside of one patient. This he said is not properly compensable by a fee for service schedule.

Dr. E agreed that the specialists they need in Children and Women’s Hospital are in high demand everywhere in the world: they are very hard to develop and very hard to replace. Each of the sub-

specialists he mentioned is in short supply in Canada and certainly internationally in anesthesiology.

In re-examination, mention was made of a sub specialist who was one of the prime movers behind the CASC agreements. His CASC salary is in the range of $480,000. The doctor added that special arrangements were made to make his own compensation more workable, amounting to about $285,000 for working 45 to 50 hours on call weeks and 85 to 100 hours on clinical ICU.

He was asked why only some of the doctors at the hospital were on CASC agreements and some are not. He replied:

> They were all invited to participate in the CASC arrangement… The process had commenced with the department of pediatrics, for example. We in our own division had prepared a proposal and wished to go ahead with the surgeons and anesthetists. But new government came in and chopped it on the head. So once the contracts were signed for the surgeons and anesthetists, the administration deemed that other positions were not to enter into compensation packages.

He also said that the salaried physicians have a benefits plan that amounts to about 20% of salary and their overhead which he would expect would be about $75,000 if he were in private practice.

Dr. F

Dr. F. graduated from medical school in Cape Town, South Africa in 1992. After spending two years in the U.K. he came to British Columbia in 1996 and opened a practice in Logan Lake. He left there in December, 2000 and is now enrolled in an Enhanced Skills Program in emergency medicine.

Logan Lake is 55 km north of Merit . It has a population of about 2500 in the town, but there is a very substantial copper mine 15 km from the town employing about 1,100 miners and other staff. Although 70% of the mine employees live and drive to the mine from more distant locations such as Merit, Kamloops and Ashcroft, Logan Lake is their emergency medical center. Also, there is a young offenders camp nearby with 30 or 40 residents who also use Logan Lake as their medical center.

There was one other general practitioner in Logan Lake when Dr. F arrived there. This other physician stayed for about two and one half years before moving to Cranbrook, leaving Dr. F as the only doctor in the town for the next year and one half. There are no specialists in Logan Lake, and no hospital, but there is a Health Center. Ten years ago, there were three doctors and an optometrist in Logan Lake working out of the Health Center, and an obstetrician and a pediatrician who each came once a month to see patients.

Dr. F's on call schedule was one in two, shared with the other physician. At first they were not paid anything for on call. After the Dobbin report in 2000, they were paid a stipend of $30,000 in exchange for a commitment to provide 24 hour on call service 365 days a year. On an hourly basis, this worked out to about $10 an hour. This post- Dobbin plan provided different rates depending on whether the town had a hospital. Both Merit and Ashcroft have small hospitals so the physicians there were paid up to four times more than Dr. F received. He explained that a month's service in Logan Lake earned what a Merit or Ashcroft doctor would receive on one

weekend. This differential made it almost impossible for him to find a replacement if he wanted to take a weekend off, or a holiday.

The difference between a Health Center and a hospital was that the latter had staff that would prepare the patient and call the doctor when the patient was ready to be treated whereas he was all alone. Thus, if a patient called him at night, he had to open the clinic, check out the drugs, set up the intravenous lines, look after the patient, and clean up after the patient left, including blood or vomit, and remake the bed and then lock the place up again. This, and the pay differential, left him with the view that his services were not as valuable as doctors in other communities because he was doing a lot more work, and getting paid a lot less.

In a typical day when he was on call he would have patients booked all day, but when a call came he would have to leave his patients and go to the Health Center, treat the patient and then return to his patients. Usually, in the evening, he would be called at least twice before midnight, and occasionally he would be called after

midnight. On weekends, he would see anywhere from 10 to 30 patients on both Saturdays and Sundays.

When there were two physicians in Logan Lake, they shared on call, and the stipend. When the other physician left, Dr. F was not offered the other half of the stipend. Instead, he was asked to sign a contract to provide everyday service for the same pay. He refused to sign because it would be physically and mentally impossible to provide such service except on a short term basis, such as when the other physician was temporarily away. He was advised by the Health Board that the residents of rural Canada have to face facts, and they cannot have 24-hour medical access on their doorstep, and that it was not unreasonable for them to drive 65 km to Kamloops. When he refused to sign, his stipend was discontinued, and the Health Board directed patients to drive to Kamloops. Logan Lake is much higher than Kamloops, temperatures can drop to –35 degrees, and it has about three months more winter each year, with lots of snow. He explained the difficulty of elderly patients, of whom there are quite a few, having chest pain in the middle of the night and the difficulty they would have, if they were still driving, getting to Kamloops for

necessary treatment in summer or winter. Their only option would be to call the ambulance, of which there was only one in the town and many are reluctant to tie it up in case it was needed for some other emergency.

After his stipend was cancelled, Dr. F said he continued to provide as much service for emergency cases as possible without pay, but he felt free to take weekends off and holidays which left him with “sort of guilty feelings”.

He said that being on call every other day was stressful, and after working on such a regime for three years he found it was taking a toll on his health. Permanent on call he found “incredibly stressful. I would say, you know, probably the most stressful period of my life…” He said he knew he “was at the bottom of the barrel, and he knew he could not continue working under those conditions.

He also explained that he had great difficulty getting *locum* assistance even when he was getting a stipend. Because of the differential with other towns he offered a subsidy by splitting the

earnings 75/25 with the locum instead of the usual 60/40 but that did not help.

When the other physician left, he tried to find a replacement by advertising nationally and locally, and although several came to visit, none of them stayed. Eventually, Dr. F decided to leave Logan Lake, partly due to his own health, but there were other reasons as well, including high overheads that used to be shared by 3 physicians, the difficulties of getting time away from practice, but more specially over a disagreement with the Regional Health Board about the suitability of a possible replacement in Logan Lake. This person, who had a sub-specialty in hairy cell leukemia had only a temporary license and needed some general practice to make his license permanent. Because of his very specific specialty, Dr. F did not think he was suitable for rural practice. Dr. F. thought the Health Board was questioning both his judgment and his integrity.

When he decided to leave, he gave two months notice by a written notice to every householder and he asked the Regional Health Board to do whatever it could to find a replacement. What the Board

did was to take over the management of the office by paying the overheads and they hired a physician who lives in Merit on what Dr. F described as a “sweet” salary of $165,000 without overheads to work from nine to four without on call responsibilities. Later, another physician was hired on contract who also got the benefit of subsidized overheads.

Dr. F commented that the Government’s proposal of only paying on call to physicians who undertake permanent on call is unrealistic, and grouping with neighbouring communities will not work when all participants are not locally situated. He mentioned the risk of heart attack by a patient where time is critical and weather conditions are not favourable. Such a patient can be thrombolized before transfer if there is someone on the scene.

On cross-examination, Dr. F said his license was restricted to a particular area until he wrote the CCFP exams (which he wrote in 1999), or for five years. He was free to leave Logan Lake in 1999 but he stayed for a further one and one half years.

He agreed that Ashcroft was also losing physicians even though they were receiving better on call payments than he was because they had a hospital. He understands that the Health Board is creating a primary care project in Logan Lake where the community will be served by two physicians supported by primary care nurses. There are also ambulance, voluntary fire and police services in the town.

In re-examination he said that when he was practicing with another physician, he was comfortably busy. When the other doctor left he could not see twice as many patients, but he was much busier.

Dr. G.

Dr. G. took his initial medical training in South Africa, but gained his specialty in vascular surgery in Vancouver. Vascular surgery consists mainly of fixing aneurysms, doing arterial grafts, and repairing vascular trauma damage. He worked as a general surgeon in Vancouver for two years and he is currently the Head of, and responsible for, every type of surgery in the Fraser Valley Health

Region which includes the area from Mission-Abbotsford to Agassiz-Hope with a population of 250,000.

He was asked about the concerns of the physicians in his region at this time. He said:

> Well, at the moment, what I've seen over the last ten years is an increasing frustration and rage building up amongst the surgeons, particularly in regard to the way we've been treated by government. We are just simply falling further and further behind our counterparts in North America.

Abbotsford has four general surgeons, Chilliwack has three. That means they run a one in four or a one in three call schedule. He explained what this means:

> A One thing not very well appreciated outside the medical community is that if a general surgeon is on on Monday, that means that he sees patients on Monday night. Some of the patients he gets to operate Monday night, others require investigation. I have a problem with OR access. And it means that on Tuesday he is cleaning up Monday's work. So, he works all day Monday in the office, Monday night, all day Tuesday in the office, and then is still operating Tuesday night. One in four means that he is off the next day, and then back on work the day after that - - back on call. One in three means that he is virtually on continuous call. One day call, one day clean up, back on call.

He said they have lost two obstetricians in Abbotsford over the last two years bringing them down to two which means one in two on call which he says is not sustainable. In Chilliwack they had three obstetricians but one of them was recruited away to Ontario leaving just two and they have been unable to fill that vacancy for several years. This means the remaining physicians may only be sleeping every second night. One of the remaining obstetricians suffered an injury which kept him off work for a time during which the other one was on continuous call.

Dr. G said that he is the only vascular surgeon in the region but a general surgeon in the region does some vascular surgery as well. This means that Dr. G is on call 22 days a month for which he receives no compensation except his usual FFS for actual attendances. He described his own situation:

A Right. That means for many, many days of the month I cannot be anywhere but within 20 minutes of the hospital to provide that call coverage. It means that I can go to Abbotsford and, at a stretch, maybe go to Harrison, but I can't go through to Vancouver.

My wife's an opera buff. I mean, she goes to operas alone. My son, who is eight years old at the moment, is active in sports. If I take him to soccer, I always have to make arrangements for someone to bring him home if I get called. He's a red belt in Tae Kwon Do. He's just about to go for his black belt. He's never been to the B.C. Championships because I've never been able to arrange to be able to take him down. The B.C. Championships occurs, and I can't get away, and he can't go.

During the course of the week, or on the weekends I cannot do many things which are considered normal for many people. I can't go home and have a beer. If I go out to dinner at a friend's house, I can't have a glass of wine. If we go to a movie, I have to have my pager with me, and my wife has to know that we may called out during the course of the movie.

This is in order to provide cover for people for lifesaving illnesses, which are - - This is in order to provide coverage for people with life-threatening illnesses, for which there is no alternative to myself. If I am not there, they simply die.

Q Now, as head of surgery, what problems do you face trying to get call coverage?

A What I am seeing, I have a group of surgeons who are extremely frustrated. They no longer feel appreciated in what they do. They are convinced government has no thought for their families or well being. They've watched their compensation decrease year after year, while our overheads increased. And the surgeons are saying, why should I continue to make these sacrifices when nobody appreciates it.

Now, within our region only one of the surgical specialties has more than five surgeons. That is orthopedics. By regional call basis. Every other call group is less than five surgeons, and is less than the number to provide a one in five call schedule, as recommended by the Royal College.

In order to obtain continuous cover, I am reliant upon the goodwill of the surgeons to continue to make sacrifices, to

> continue to lead what is often an unacceptable lifestyle, to continue to put stress on their families and, in many cases, to subsidize the system by taking a loss.

Dr. G. was asked about the Government's position that there will be no pay for on call unless 100% coverage can be provided. He replied that this makes him very angry. He already has obstetricians working one in two or three days and running a practice as well, and the governments says to them " that when one of you is away, or one of you is ill and you cannot physically do that [100% coverage] we're not going to pay you." He said he has spoken with his sub-specialists who tell him they cannot provide full coverage, although they are trying, and if they are not going to be paid, they will not do it.

He also said that his specialists were insulted and demeaned by the proposed specialist stipend that applied only to some of them but not to plastic surgeons or ENT physicians and it was only by his personal persuasion that the specialists have continued to provide close to 100% coverage without taking job action.

Dr. G described the staffing situation in his region. In obstetrics and gynecology they had seven in the region but they went down to three but they have been able to recruit two so they have three at Abbotsford and two at Chilliwack. He added that “virtually every night the obstetrician is called out”.

With general surgeons, they have four in Abbotsford, one of whom is about to retire. They are looking for a replacement. In Chilliwack they have three but they have been trying for years to recruit a fourth. Because surgeons on call usually spend many hours in the hospital, it usually means they operate two out of three nights in the hospital. In addition, they are required to take continuing education courses (100 hours for himself) which means others have to cover for them while they are away. He said they should have ten general surgeons in the area, which would be one for every 25,000 persons.

Orthopedics is the best situation they have. They have six but they lost one to Abu Dhabi. They do call on a one in six regional

basis but that means a lot of travelling back and forth in the course of a call period.

ENT coverage is provided by three surgeons, two of whom are elderly and will be retiring fairly soon, and one of them has to undergo surgery himself and is unlikely to come back so recruiting will be necessary, hopefully to bring them to four.

Plastic surgery is provided by one surgeon in Abbotsford and one in Chilliwack . They cannot provide one in two call coverage, but they provide one in six each.

Urology service is provided by three doctors. One recently retired and they were able to recruit a replacement, but they are facing retirement for two of them within the next few years. They work on a one in three regional call.

Vascular surgery is covered by himself and one general surgeon who does some vascular work. He does 22 days on call a month, and the other doctor covers the other eight days.

Anesthesia varies between sites. In Chilliwack they have four serving on call on a one in four basis, but if called out at night they generally cannot work the next day which affects their income. At Abbotsford they had seven but they are down to five which means they cannot run all their operating rooms in Abbotsford and Mission. They have been trying to recruit another anesthetist for at least two years without success.

Staffing emergency rooms falls mostly on family practitioners who are expected to work to 11:00 pm, but often do not get away until 12:00 or 1:00 am which impacts on the next day's work. The overnight call is even worse because the doctor is often busy until 6:00 am which usually means no sleep, and the doctor has to work exhausted the next day or cancel his office. For this, the doctor is paid $200 or $250 while continuing to pay his staff. For these reasons, more and more doctors are saying that they are not going to do on call anymore.

With regard to recruitment, Dr. G. said:

A Over the last year and a half, as head of the department I've been very, very actively involved with that. We are continually trying to recruit on all fronts. We place ads. Those responses that we do get, we fly them in - - and their spouses and whole families - - across to come look at the region. We wine and dine them. And we, nine times out of ten, find that we simply can't compete from a financial basis with what they're getting elsewhere.

When asked about the effect of the government's decisions on call in Prince George and Vancouver on his physicians, Dr. G. replied "rage" because his group were providing more on call service than the physicians in Prince George or the doctors at Vancouver General who are getting $6,000 a month. He said: "This is telling me that my time, the time of the surgeons working in our area is just not appreciated. I cannot emphasize enough how angry we are about this."

When asked about his personal views, Dr. G. said:

A I am hopeful that things will change, but the present situation that I find myself in personally, and that I see my colleagues in, is not sustainable. Every one of us every month receives unsolicited job offers from around Canada and from the U.S. Most of these are extremely tempting financially, and I think if we do not change, we are going to see further attrition within our ranks and, accordingly, loss of patient care.

In cross-examination, Dr. G said that when he arrived in the Fraser Valley region there were about 40 vascular cases a year at each of the two major locations. Now they are up to 240 to 250 cases in the region.

He was asked about the possible regionalization of vascular surgery in a major center, but he said the problem with that is simply that these kinds of patients usually need surgery immediately, and they are usually fragile who do not travel well.

When asked if he thought the fee schedule for vascular surgery is under-valued, he said:

> It is my view that every surgical specialty is undervalued in B.C. behind Alberta, we are behind Ontario, which are our main competitors, and we are so far behind the United States.
>
> What you need to remember, and remember very carefully, is that virtually every specialist, when they get their qualifications, just pops across and writes the American Boards. They're easy compared to our exams.
>
> So, when we are competing for people, we are competing across North America for them, and we are just not competing at the moment.

Dr. G. also observed that specialists at the teaching hospitals are paid $6,000 a month to do one in six call while he gets nothing for 22 in 30. When asked if he thought FFS was appropriate for his specialty, he said he is not paid for his availability. It was suggested to him that being paid for his availability would not change his life because only an extra vascular surgeon could do that. He replied that if he was paid properly, he could at least operate during the night and cancel his office for the next day without losing revenue he needs for his overhead. He said it would also change his sense of well being and of being appreciated. He went on to say:

A When we look at life, one of the very fundamental parts of life, one of the fundamental reasons that we can enjoy life is that we can see things getting better. If you can't see things getting better, then they're just getting worse. If you - - Every day if you wake up and you think things are just going to get worse, all it does is lead to burnout, depression, anger, rage. That is the cycle that we are in. That is a cycle that this arbitration has the capacity to break. That is why I am here today talking to you. This is why I came down the night before, and left my family - - was to convey that information.

I think it is vital to the well being of the system that recognition is given for not just the time I pick up the scalpel, but for the time that I am prepared to pick up that scalpel. I am asking for recognition for what I do. I am asking for recognition for what

> the staff of my service does. And, at the same time, I am asking for recognition for what all the specialists and family docs so in this province day in, day out. This is more than the Hippocratic Oath, this is future.

When asked if he agreed the decision to pay on call in Prince George was a mistake he said being paid for on call is right, but what was wrong was the inequality, and by localizing it to one site breeds anger on the part of the people who are excluded. He wants universality. He said:

> A What I would like this panel to do is award, or make a ruling so that there is an on-call payment which is universal - - I am talking for specialists here - - for specialists who do call across the province.
>
> My time, the time of the people in my service, the time of people in Prince George and Prince Williams and Castlegar is worth the same. We're talking about the inconvenience of being on call, the impact on family, and the lack of appreciation therefore. I do not want to see the system where one person is held to be more valuable than another.

He said one obstetrician who is near the end of his working life, and is wealthy has gone on a world tour; another has gone to Ontario; a general surgeon who is burnt out has gone to Saipan and has been replaced by a South African practicing in Prince Rupert; an orthopedic surgeon has gone to Dubai and cannot be replaced; an

ENT surgeon at Chilliwack has gone to Saskatchewan where he is paid better because he was on call continuously here and he has been replaced by another South African but two of the remaining ENT surgeons are elderly and likely to retire and one of them has to have surgery. Dr. G. refuted the story in the newspapers that an advertisement in Britain resulted in 300 replies by family practitioners because he said that so far as he is aware, only one of them is coming to have a look at the Fraser Valley.

Dr. H.

Dr. H. graduated from the medical school at the University of Ottawa in 1992 and qualified as a specialist in gastroenterology in 1998. He practices in a clinic with four similarly qualified specialists in the Simon Fraser Health Region which includes hospitals in Burnaby, New Westminster, Coquitlam and Maple Ridge serving a population of 750,000 persons. He and his associates are the only gastroenterologists in the region.

He said in the three and one half years he has been in the

region he has noticed a “perceptible change in physician morale and attitudes.” He said they are becoming increasingly frustrated, the major factors being work load, what they are paid for (on call responsibilities), increased administrative difficulties, and providing safe access for patients to the doctor’s office.

He said his office waiting list has expanded to the state where it is unsafe and that family practitioners are regularly phoning to ask that their patients be accelerated and that takes time away from time he should be spending with his patients.

He said in the last two years, they have lost two general surgeons, a head and neck specialist, and a vascular surgeon to Edmonton. Also, he said a “huge” number of family physicians – probably approaching half of the staff at Eagle Ridge and Royal Columbian - have resigned their hospital privileges in the last year because of on call and Doctor of the Day responsibilities; a specialist in rheumatology left for Abu Dhabi two years ago; one of his partners went on stress leave; and two emergency physicians have gone to Saudi Arabia. He described this as a huge loss for the size of their

staff.

He said physicians have been leaving for different reasons but the most serious are overwork and having to increase it further by unpaid services are the main reasons.

Recently, they were able to recruit a vascular surgeon from another B.C. community but the general surgery, rheumatology and emergency posts have not been filled. Because of a lack of family practitioners, the hospital has been forced to implement a hospitalist program. He was able to recruit a new associate quite recently but it was a long, arduous process. He and his associates thought they would get many applicants because their hospital is one of only a few in the country that is a large tertiary care center where physicians can teach without getting into a university association, and they can also practice FFS, but they were turned down by several prospects. A specialist from Ontario turned down their offer because he was concerned about the system here where he would have to work so hard to earn the income he expected.

He also said he and the new associate are the only members of his department under the age of 40, and over 50% are over 55. He said that B.C., being a desirable place to live is no longer enough to attract good prospects. In pediatrics and neonatology they have been advertising for over two years. Recently they hired two, but they came from other B.C. communities. He, personally, has received offers from Calgary, Edmonton, Toronto and the United States. He said they are trying to recruit 5 gastroentologists in both Calgary and Edmonton. Two of the doctors who graduated in his year ended up in Calgary.

He has been on one in three on call until recently. Now it is one in four but it comes from all the hospitals in the region, and he gets no pay for it. On call, he said, has a big impact on his personal and professional life, particularly as his waiting list continues to grow and he has no flexibility to reschedule anyone and sick people always take priority. If he were paid for on call, he would decrease his office load and maybe take an occasional Monday or weekend off. He said the frequency of calls averages three or four consultations in the hospital in a 24 hour period but it can be more or less.

He was asked about the government policy to classify some specialties, such as gastroentology as non-core for purpose of paid on call. He said he thinks this is unfair for Government to decide that some specialties are more important than others, especially when his specialty is responsible for foreign bodies in the esophagus, bleeding in the stomach and bowel patients, especially the serious ones, liver disease, inflammatory bowel disease and certain emergencies such as leaking bile ducts after colocecostomy.

To make things better, Dr. H said that B.C. must become competitive with Alberta and Ontario that are the other major training centers. He said we are not competitive now. He gave the following evidence:

> A. Well, I think that, you know, we've been at fault in many ways, as physicians, for perpetuating the system the way it is. And we've done that because we've felt it was best – in the patients' best interest. And despite the fact that we're here talking about some of these compensation issues, the bottom line for most of us is that patient care is the most important thing.
>
> I think what we've seen happen is that as we've been willing to do more and more for free, and more – and our work load has

> increased and we're just not able to sustain that anymore. And now, despite these efforts, patient care is suffering anyway. So, I think that that's been a mistake.
>
> Q. What in your view, is going to happen?
>
> A. I think we're going to see more of the same happen, and that's, that we're going to continue to lose physicians, and we're going to have difficulty replacing them. And we're going to lose – not just lose physicians who are going to go to greener pastures, but we're going to lose physicians through attrition, and we going to have difficulty replacing them, as well.

In cross examination, the doctor said there are about 15 to 20 gastroenterologists licensed each year nationally and the decision to add to the staff of this sub-specialty is made jointly by the hospital Selection Committee and by the practicing physicians. As stated above, the group is presently short the one member who is on stress leave and it is not known if he will be able to return to practice.

Several hospitals in the region have now employed hospitalists to look after Doctor of the Day responsibilities.

He said the vascular surgeon who went to Alberta did so because he was not getting enough operating time. That surgeon told Dr. H that he was expected to be on call but he wasn't making

any money. Dr. H said he doesn't know any surgeons who think they are getting enough operating-room time. Finding enough nurses is also a problem in staffing operating-rooms.

The neck specialist who left to take a prestigious position in Alberta has returned to practice at St. Pauls hospital. He returned for family reasons.

He said the physicians who go to the Middle East usually do so for financial reasons and because they are frustrated in their present position. These salaries are paid in U.S. dollars, there are attractive tax considerations, and they have an advantageous leave arrangement for conferences and family visits.

Dr. H. said that emergency doctors are far more likely to call in a gastroenterologist now than previously because of the increased service they provide, such as stopping ulcers from bleeding with scopes through the mouth instead of major abdominal surgery. They also do laparoscopic surgery for gallbladders, examine the liver and bile ducts.

He said that his group has one operating-room that runs for three and a half hours in the morning and afternoon from Monday to Friday that they divide among the four of them. That works out to about one and one half days a week, which he said was not very much time for a specialist. He said the trend is to do endoscopic work only at the Royal Columbian which is becoming a problem because of the population growth in the area. They take call at all the hospitals in the region.

Dr. I.

Dr. I graduated from McGill Medical School in 1966, and he interned at the Montreal General Hospital before going into the Navy where he served for three years as a general practitioner on a navy vessel. He then opened a general practice in Prince Rupert in 1970 where he also served as the local anesthetist for 20 years before moving to a family practice in Campbell River. He looks after a wide range of ages and conditions and provides on call emergency services for the hospital as there are no emergency specialists at that

location. In his community, the doctor on call is also the Doctor of the Day. In order to get remuneration that's recently been made available, they have to provide 24 hour on site services even though his office is closer to the emergency ward than is the far corner of the hospital. On weekends the work load is so heavy that two doctors must be in the hospital at all times except over-night when there is only one. There always has to be a back-up available in case of a heavy emergency or the on call physician has to undertake surgery.

Because Campbell River is the largest center in the north of the island, they get lots of referrals from the many small communities. Campbell River is also an industrial town with logging, pulp mill and mining so they get lots of trauma cases. There are some specialists there but the general practitioners usually have to see the serious cases first.

Prior to June, 2000, there was no payment for on call which caused a great deal of unhappiness as the doctors where spending a great deal of time without compensation. He described the dislocation caused to his office when he was required to be at the

hospital for several hours, and when he had to cancel his office appointments because he had been up all night.

The payment offered was $590 for 24 hours of call that had to be divided between the doctors working the various shifts but because the doctor doing the overnight shift could not usually work the next day, they decided to pool their remuneration and give it to the overnight doctor to cover his overhead when he was unable to work.

The doctor said he is usually on call one weekend a month, and sometime two, and on daytime call three or four days a month. An equal number of days he would be on backup that requires him not to be on site, but “available, sober, and within telephone distance and able to get to the hospital immediately”.

Dr. I said that on call did not bother him much when he was younger, but now he wonders why he is doing it as it affects his sleep which he needs now that he is older. He said it really exacts a toll as you get older. He also said that a doctor who receives a patient in

the hospital has to look after him or her when released and this requires him to look after patients that he would prefer not to have as his patients. He said they are usually without their regular doctor, often non-compliant and abusive.

He said there are not enough family practitioners in Campbell River to service the area properly. They have had a recruitment program going on continuously for a number of years and it is difficult to get physicians to practice there. Campbell River has been designated as a community in need which is intended to be a program to assist recruitment. About three years ago, his clinic lost four doctors suddenly – one to illness, one to retirement at age 67, one who went to Victoria and one who joined another clinic, leaving an eight doctor clinic with just four doctors. He said they went on an extensive hunt for physicians but they received only one casual inquiry. They then looked to other provinces, but found competition very strict and received only two telephone responses. Eventually, they attracted two doctors, one from northern Ontario and one from northern Saskatchewan, one of whom has left because he did not

wish to work as hard as the others, and he went to a community where he did not have to work on call.

He said it is very difficult to get *locum* coverage. Most such physicians are booked a year or a year and a half in advance.

Dr. I said the doctors in Campbell River are not happy about their compensation having regard to the hours they have to put in and the amount of unpaid work they have to do. He said:

> The Closer to Home Programme got people out of the hospitals into their homes, and now we – now they are treated, via a nurse, over the telephone. And we don't get remunerated for doing that, and we spend considerable amount of time – all of us – dealing with those folks and directing their care over the telephone.
>
> It's risky, as well, because you're never sure that the information that you are getting that you make decisions on is accurate. The quality of the folks who deal with these people varies, and some report well, others don't report that well.
>
> And the need to provide service to the hospital in terms of being on committees, and trying to keep the hospital running in a reasonable fashion – again, unpaid. Going to committee meetings where everybody sitting around the table who is not a physician is being paid, and the physician is doing it for free, upsets people a great deal.

In cross examination, Dr. I agreed that $590 a day on call services, shared by 10 physicians amounts to $215,350 ($590 x 365). Dr. I also does two clinics a month at a youth camp on behalf of the Ministry of Families, and he is an inspector for the Medical Services Plan doing sessional work on patterns of practice. He also works about an hour and a half a week doing hospital administration work assessing patients for discharge.

Dr. I said that he hopes that by next Spring they may have two more physicians working in their clinic for a total of six, and possibly another one from South Africa.

There is another clinic in Campbell River where two women physicians each work about three days a week. In his clinic there are two women physicians, one works about three days a week, and the other is on maternity leave and it is not known if she will be returning.

Dr. I was asked about the different attitude of young physicians. He said:

The difference is that new doctors coming out are not prepared to spend the amount of time of their lives practicing medicine, and I think they look at medicine differently. They look at it as a job, and they want to – they want to work the same sort of hours that other people who have jobs do, and they want to be remunerated in a fashion that coincides with the amount of training they've taken, and the job they do – the responsibility that they have. And they're – And that's – I think, is now being instilled from the university on.

When I went through medical school, people of my vintage we were trained to be workaholics. We were told that's what you have to do, and we just accepted, if you want to be a doctor, you have to work your buns off, and you have to work long hours. And that's – You know, that's what you have chosen, so get in there and do it. And a lot of us did.

You know, you can still talk to physicians older than I, who worked as interns for cigarette money. I made the glorious sum of $300 a month, you know, working 12 hours – 12 hours a day or more as an intern. That doesn't happen anymore. And I think the big change came when the interns and residents decided to become a union.

And so, the attitude of folks coming out now is that, you know, I am not prepared to spend 12 – 14 hours a day doing this, I am not prepared to work for nothing, I am not prepared to be on committees and not get paid when everybody else is getting paid. So, the whole attitude of physicians coming out now is very, very different, the result of which is that you are going to need a lot more doctors than you did before to do the same work.

Dr. I was asked if younger doctors are interested in contractual specified obligations, but he did not agree. He said younger doctors

want to have a good life style. He said they take lots of holidays, and he added that":

> *Locums* are notorious for that. "They do *locums* for a short period, and then they're off walking the hills of Nepal. You know, I would have never even considered doing that, you know, when I became a doctor. This was going to be a full-time job for me, and almost 24 hours a day. That's not the attitude of doctors coming out of training programmes now.

Asked again if young doctors are interested in blended payment salary, plus FFS, he replied he was not sure. Some would, he added, but it varies from person to person depending on what is offered.

Dr. I was asked about women doctors, and while saying he had no problem with women doctors, it is a fact that many of them work part time. He said there are increasing numbers of husband and wife doctor families where, in many cases, the wife works part time. He said there are four or five woman doctors in Campbell River who work part time. He added that if the medical schools are going to double the number of woman doctors, then you must double the number again to get the same amount of service.

Dr. I did not agree that expectant women are necessarily interested in having a woman doctor because so many such doctors work part time, that the patient has a five in seven chance that she will have a male doctor anyway. In fact, he said that most of the women doctors in his community do not do obstetrices.

When asked about practice in other communities, Dr. I said he does not like the regime that exists in some locations where a doctor without hospital privileges sees a patient and sends them off to the hospital when they are really ill where they will be looked after by someone else, and then come back to him or her when they are better. He prefers to practice in a small community where they look after their patients “in total’. He said they do not have a Walk In Clinic in Campbell River, but both his and the other clinic stay open in the evenings and on weekends.

Although he had some training in anesthetics, and did a lot of that kind of work in Prince Rupert, he does not do it anymore because the hospital preferred not to use general practitioner anesthetists. Now, because of a shortage of about 189 anesthetists

in Canada, the hospital is looking for two of them but he said you can't find them anymore. At the moment, the hospital has no choice but to use general practitioners as anesthetists.

Dr. I also said there are Health Centers in native and rural communities around Campbell River and only some of them have physicians. The Campbell River doctors provide services to those people when they have serious problems.

Dr. J.

Dr. J graduated from the Faculty of Medicine at the University of British Columbia in 1976, and he completed a general surgery fellowship in 1981 followed by a thoracic surgery fellowship in 1984. He has practiced since that time at the Vancouver General Hospital and he has been an associate professor at UBC since 1992. This involves him in all aspects of undergraduate and postgraduate teaching at the Faculty of Medicine. He is Head of the thoracic surgery division at the Vancouver General Hospital.

Thoracic surgery involves all aspects of surgery in the chest,

such as lungs, esophagus, mediastinum, chest wall, diaphragm and everything in the chest except the heart. 80% of their work is malignant work or cancer-related types of surgery. He is a member of a number of Faculty and Hospital committees and attends meetings virtually every day, and sometimes two a day.

In BC there are 10 chest surgeons plus one that is just returning from extended leave. Over the last four to five years there have been retirements and departures. One left Richmond to practice in Ontario and more recently, during the last six months, one left permanently for the Middle East and the other one practicing in Surrey has gone to Edmonton, leaving just the eleven mentioned above, of which only two are at the Vancouver Hospital, General site.

His understanding is that those who left departed mainly for financial reasons. He said they need four surgeons and they have been trying for the least year to recruit another surgeon without success so far.

He said the main difficulty recruiting physicians is the limited

resources; mainly hospital beds and operating times, and secondly, competition with the rest of Canada with respect to the fees paid in this province. The last resident they trained and retained in this province was in 1996 and he is now practicing in Edmonton. They have trained two others who have both accepted appointments in Calgary. The present trainee who was slated to operate the lung transplant program (they do about 15 a year) has decided to practice in Edmonton.

The doctor said that Canadian chest surgeons are exceedingly well trained and competition for them comes from the United States and all parts of Canada because there is a national shortage at the present time. He mentioned that three of the four thoracic surgeons at the University of Washington are Canadian citizens trained in Canada. He mentioned another Canadian who was with them two or three years ago has taken a position at Ann Arbour, Michigan.

Dr. I said he and the other chest surgeon take “one in two call” on a weekly basis at the hospital. He explained that during week that he is not on call, he goes home on Friday, and returns to the hospital

Sunday night to see his pre-op patients. When he is on call he is usually at the hospital every day of he week. When one of them is away then the other is on call every day.

The Vancouver Hospital is the major referral hospital for the region. There is some chest surgery done at St. Paul's, but not much, and he and his colleague do most of the work referred from the North Shore, a large part of Burnaby and a lot of the Fraser Valley as well as the Yukon.

He said there is no formal scheme for payment for on call services at this time. About a year ago, the President of the hospital proposed an academic stipend of about $20,000 per month for each surgical group or division. He said this came about as a result of great dissatisfaction with hospital cutbacks and in an attempt to satisfy a lot of grievances by surgeons. He said this was a good start, but it needs to be formalized.

He said a two surgeon group in his specialty is not "sustainable" when both are 50 years or older. The on call can be very demanding

on top of the day to day work they do which involves long hours in the operating room as well as their teaching and administrative responsibilities plus running the only thoracic training programme in Western Canada. Apart from on call, he says he works a minimum of a 12 hour day. He is concerned about the patient service and teaching which requires about four hours a week and he said the expansion of the medical school cannot be sustained until the manpower issues are addressed in a serious way.

At the hospital they have established an infrastructure of dedicated chest radiologists, pulmonary pathologists, a core of thoracic anesthetists, as well as nurses, occupational therapists or physiotherapists and home care people that assist with the transfer from hospital to home. As he said earlier, this infrastructure is not sustainable with just two surgeons, and he mentioned that some physicians in other centers are trying to practice alone, but he said that is simply not sustainable in the long term.

He described the effect of a lack of thoracic surgeons in a tertiary care hospital such as the Vancouver Hospital. He said:

> In a tertiary hospital you need sub-specialists to provide the infrastructure to do what hospitals are supposed to do, namely look after patients. So if we don't have a neurosurgeon or if we don't have a thoracic surgeon there's some things that you can't take. You won't have a level 1 trauma programme for example. You probably won't have a trauma building. You won't be able to provide coverage for in-hospital patients that get sick unexpectedly with thoracic problems. You won't have a provincial intensive care unit. You definitely won't have a lung transplant programme. And you definitely won't have a thoracic surgery residency training programme.

The doctor was asked about CASC agreements. He said it was a concept where a group of surgeons for example is paid on a contract basis to do what they do best which is to look after patients and do academic work (teaching) and research. He said the hospital administration recognize that:

> …we are in a survival mode right now. We're facing manpower crises in certain areas. In actual fact, my area of interest is probably the one that's right on the edge right now because we're the smallest surgical group in the hospital. You can't get much smaller than two… in order to keep the infrastructure that we need they had to look at guaranteeing the specialists something.

He continued that a CASC agreement is a package that includes all the things he had mentioned, as well as on call services. He said that if the CASCs had not been offered, he could only speculate, but last year, “when surgeons’ incomes were down because of access issues, because of nursing shortages, and --- all the headaches …I can only suggest that people would have left” and recruiting would certainly have been even more difficult than it is now, and he added, and it’s tough right now.

He said the process for CASC agreements must be competitive with the rest of the country, particularly Alberta where there are contracts that he thinks are standard. He added that the fee for service aspect of the work we do here is much more lucrative than here, and it has been for sometime. He said the basis for CASC agreements is comparison with Alberta.

The doctor was asked about physician morale at the Vancouver General Hospital. He said the physicians are suffering from a disease he calls “the dwindles” which he described as:

> Everybody is running out of gas. At every level of health care there's difficulty. We have a lot of difficulty getting sick patients into the hospital. We have difficulty getting patients out of the hospital. We have difficulty getting patients transferred back to other hospitals. We have difficulty getting patients into our hospital from other hospitals. And we are paid much less than we think we are worth.

When asked about workload compared to colleagues in other areas, he said:

> Well my partner and myself looked at our workload last year for the 12 months and we basically compared it to the Alberta fees after the Albertans had their last fee increase. And what we found was that we were working almost twice as hard as – as they were for about half the amount.
>
> And when we look at the actual fee for service items in the Alberta Fee Guide there's quite a disparity. And some of the fees in Alberta are actually 100 percent more than the thoracic surgical fees in this province."

When asked if he has received expressions of interest or efforts to recruit him into other provinces, he said he and his partner do receive such inquiries. He added that they are both highly trained both as general surgeons and thoracic surgeons and with a national shortage, it's a very competitive market. That, he added, is why they are having so much trouble recruiting new surgeons but he stressed

that they also have to retain the ones we have now. He said they have not been able to retain a chest surgeon for a number of years; they lost two in the last six months, the last trainee they kept was five or six years ago, and “we are right on the edge.” He said the average age of chest surgeons in BC is 52.

When asked how long it takes to train a chest surgeon, he replied that most physicians complete their training in their early 30’s, but he did not start to practice until he was 34 because thoracic surgeons have to qualify as a general surgeon first.

In cross examination, Dr. J. Explained that the predecessor of thoracic surgery and cardiac surgery was known as “chest surgery” that was principally involved with the treatment of TB. In the 60’s the technology for cardiac surgery was developed and as medical care for TB improved, the two separate specialties of cardio and thoracic surgery were identified. Then, the doctor said, changes in the incidents of disease, particularly thoracic malignancy became the focus of his specialty. He added that they are seeing an increased incidence of lung cancer in women and adenocarcinoma is “taking

off" in North America. Cancer related chest disease is a significant part of his department's work, but they also do all aspects of thoracic surgical trauma, although the latter is low now because the hospital has a first line trauma service that does the initial resuscitation.

Dr. J said there are four thoracic surgeons in the Okanagan, two at the Vancouver General, none in Richmond, Surrey or North Shore and one at St. Paul's who is part time, and two cardiovascular and thoracic surgeons who do some chest surgery. He said it would be best if thoracic surgeons were concentrated in two or three areas of the province. In fact, the Chest Surgery Association believes the Government should be promoting the development of sub-specialty units in concert with people who are trained in that kind of work.

At the present time, only one thoracic surgeon is trained every two or three years because it takes three years of training after completion of general surgical training. They can only train one in their presence circumstances here but they could train two if they had a bigger facility. There is no such training in Alberta or Saskatchewan and only one is being trained in Manitoba. Each

province is trying to attract the new graduates.

Doctor I is the Head of the hospital division and his colleague was the head of the university division until last June. His colleague was very involved in the development of the CASC concept .

As the medical sub-unit manager of respiratory sciences, the doctor is administratively responsible for all surgical units that have anything to do with lung disease which is a 44 bed unit for which he is paid a stipend of about $20,000 a year. His FFS billings last year were approximately $400,000. He said, however, that the fee codes in Alberta for similar work are much higher, and in some cases twice as much. He added that the last two thoracic surgeons trained here, and the one who is about to complete his training here, have gone, or have agreed to go to Alberta to practice. He also receives an academic stipend of about $10,000 annually which he said was an amount the previous hospital president set up so the surgeons would not walk away. He also receives a similar stipend as clinical associate professor at the university. The figures he mentioned are gross figures, that is before he pays his overhead costs.

In re-examination, the doctor said his average working day, is 12 to 14 hours, excluding on call, which often includes night work, and weekends.

He said the surgeons at the Vancouver Hospital have been very concerned about not being able to get adequate access to fully staffed operating rooms. One proposal was to increase caseload by 15% to reach the previous year's rate. Another one was to increase cancer patients for approximately 200 a year because of the increased incidents of malignant thoracic disease. Neither proposal has been adopted.

He was also asked about the negotiations for a CASC agreement. He said these negotiations have not been finalized. He said he and his colleague based their proposal for an annual salary of $550,000 which is the amount paid in Calgary for each thoracic surgeons in a group of three (shortly to be increased to four at the same salary). He said these doctors in Calgary are:

> …not running a training programme; they're not running a transplant programme that we're doing, they're not doing any of the academic work that we're doing, they're not doing any of the research that we're doing…

He added that he did not seek to enhance his proposed CASC salary for any of the additional services he had described.

Dr. K.

Dr. K. is the Deputy Provincial Medical Health Officer for the province of British Columbia, located in Victoria. He took his medicine at Cambridge University, England, in 1964 and came to Canada in 1969 and practiced here as a family practitioner until he took a Masters Degree in Science at UBC in 1980, and qualified as a specialist in public health. He has been practicing as a medical health officer in Prince George, Vancouver and Victoria under the Salaried physicians Agreement. He described his duties :

> I work closely with the provincial health officer. Our responsibilities are defined under the Health Act to monitor the health of the population of British Columbia; to produce an annual report on the health of British Columbians; to advise Government, the public, in an independent manner on health issues in B.C. We're also responsible for establishing

> professional standards for all the medical health officers in the province and to monitor those standards. And we can order a medical health officer to take action if we feel that it is necessary to protect the public's health. All this is described in the Health Act.

He explained that they watch particularly for outbreaks of particular illnesses, and they work closely with the local MHO's and the Centre for Disease Control such as the risk of anthrax that was a problem at the time he gave his evidence.

There are 17 physicians employed by the Ministry of Health, or on contract to agencies where they may get paid more. All are experienced physicians who are experienced in clinical practice.

Dr. K is paid $113,000 a year under the salary agreement that was negotiated in 1992 or 1993. At that time the group also included those physicians employed at the B.C. Centre for Disease Control and psychiatrists at Riverview and a few others but now the group includes only those physicians employed directly by the Ministry of Health. There was a salary freeze initiated in 1993, and they have received only minimal salary adjustments, since then, such as 1% in

1997, 2% in 2000 and 2 ½% in April, 2001. The MHO's have been negotiating for a salary increase for some time but they have been advised that there will be no increases until the completion of this Arbitration. He said the Provincial Health Officer is paid $149,940.

Dr. K. said that the Government has taken the position that MHO's are not represented by the BCMA. He added that he only knows of two employed physicians who advise the Ministry on "physician remuneration and that sort of thing."

In cross-examination, Dr. K. agreed that the average life expectancy of British Columbians is about 79.5 years which is better than any other province, and at the level of some of the best countries in the world like Sweden and Denmark. He said:

> British Columbians are healthier than most other provinces by traditional measures: infant mortality, length of life, etc. (and he added that Richmond and North Vancouver have average longevity of 81.5 years – the longest in Canada).
>
> …We know it's not just – health services certainly play a part in improving the health and how long people live. But we also know that incomes, we know that the education of the population, we know that early childhood, we know that social support systems, all these things play a part.

Dr. K. said that a Masters degree is essential for appointment as a MHO in this province. He described some of the functions of a MHO which include overseeing the operation of statutes and regulations relating to communicable disease, sanitation, collection of community health status, operation of food premises and ensuring compliance with numerous statutes. He said he had just completed a special report on drinking water quality for the province. He also mentioned influenza, immunization, and meningitis. With respect to the latter, he was personally involved in an outbreak in Abbotsford and in the policy decisions about whether there should be a major immunization campaign.

He was asked if he believed health outcome is more related to public health indicators than the role of surgeons at the end of the line. He replied that the role of the MHOs is the health of the public as a whole and he added that some physicians who provide one-on-one care don't understand what public health is all about.

In addition to his salary, Dr. K. has benefits and superannuation entitlement comparable to other senior managers in Government who were subject to the same salary freeze.

Dr. L.

Dr. L is the Medical Health Officer for the Vancouver-Richmond Regional Health Board. He graduated from the University of Alberta Faculty of Medicine in 1969 and qualified as a specialist in public health in 1976. From 1984 to 1986 he was chief medicinal health officer of the City of Vancouver, and then, after the creation of the Vancouver/Richmond Health Board, he served for nine months as CEO of the Burnaby Health Region before assuming his present position.

Dr. L gave a comprehensive description of his duties that is worth quoting. He said:

> The major areas that my job now entail is in communicable disease control. So all aspects of communicable disease control. Adverse reactions; investigating and following up on any adverse reactions to

immunizations. Things like influenza, we do control within the community care facilities. And so we -- actually my staff and I will go into a facility that's experiencing an outbreak and write prescriptions for amantadine and order tests to be able to continue the course of amantadine. We do investigations for things like meningitis. And again, we'll go out to a day-care and write the prescriptions so that the kids can get started on their medications right away. So that's right hands-on, front-line medicine.

TB is a major area that we work in. While tuberculosis is virtually extinct in this province unfortunately in the Downtown East Side of Vancouver it's in the same levels as the 1890s. So we've actually put forward a TB eradication programme that we were hoping that was going to go forward. But it looks like we're going to just continue to treat TB rather than eradicate it.

We get involved in all of the enteric diseases. And so my public health inspectors follow up all enteric diseases to see whether or not there's an outbreak occurring in a restaurant. If there's a common source we can find, indicating my deputy and myself, work with physicians, call them directly, talk to them to get information to try and pinpoint the source of a – of a disease...

Environment, water, air, restaurant inspections, playground safety. I mean we've gone out and changed all the playgrounds in this city so that there's no longer cement underneath swings and that, and put sand and that in to try and stop these kids getting in hospital with breaks and things like that. So environment becomes a big part of it.

And of course in my role as the medical advisor to the GVRD I've had a big role to play in moving the GVRD to filter the water on the North Shore so that it was approved in the summertime. And in February the final funding for that will come forward and we'll get some decently filtered water. As you know at this time of year when the rains come our waters get not so clear. It's not so bad today. But it was up over one and was climbing to five the other night when I got a phone call saying: We're going to increase the chlorine, and unfortunately we also have to tell

you that the ozonisation plant is off-line, what do you want us to do?

I'm the school medical health officer. Interestingly I am the only person who can exclude a child from school in the province of British Columbia by law. The principal can exclude a child for up to five days, the medical health officer has to be involved in any decision longer than that. I take that very seriously, and we spend a lot of time on school exclusions, because the trouble is if a kid gets out of school they often don't get back in because once they're out of sight there're out of the – so we spend time working with getting psychiatric assessments, getting psychological assessments, working with the school to get them back in place.

I'm also responsible for all the health of teachers. And you'd be amazed at what teachers do. It's a pretty stressful job and so the School Act specifies that I can be asked to exclude a teacher, and can therefore ask for a psychiatric examination on a teacher. And she cannot return or he cannot return to school until I have received a report and I clear them or I report to the School Board that they should not be allowed back to school. So I spend a lot of time talking to psychiatrists and that about some pretty bizarre behaviors.

Under the Community Care Facilities Licensing Act I license all the community care facilities in Vancouver/Richmond. I am responsible for ensuring environmental checks are made, that the places are safe, that screenings are done to make sure that the people working there – and when an abuse occurs, and this is – I spend way too much of my time on this – when an abuse occurs I'm the person who follows it up, holds a hearing and determines whether a license should be pulled or some change be made to the license to protect the residents of the facility.

I do that also for child-care facilities. So all child-care facilities are licensed under the medical health officer. I don't actually sign them any more because there's so many of them. My staff do. But I hold hearings and decide whether or not a person should be able to continue to hold a license to run a day-care.

I'm an advisor to various medical councils, to the City of Vancouver, to the City of Richmond, to the University Endowment Lands, and I get all kinds of questions by the councilors.

And then I do whatever. Whatever – white powder. When we started to have the anthrax scares it became clear you could not continue every day to clear out the Nova Scotia Tower, as happened the first day before I got in and now I am the direct contact for the RCMP. And between us they tell me if it's a credible threat. If they decide it's a credible threat I tell them how high the response should be. We've not cleared any towers since then. We've not washed down and sent anybody to the hospital in white gowns to try and make their way home with no money, no shoes, no car keys – some funny incidents that occur like that.

And then I guess my other big role is to advocate. To try to advocate for programmes to get Government to do things that will improve the health of the population. And so the work that we've done in smoking, trying to get smoking bylaws, the work that we've done in noise control to try and do some controls on that. And that's sort of what I do.

Q. I hate to ask you if you do anything else on top of that long list of things. But do you actually get involved in ordering tests and prescriptions for nursing home residents and people in mental health institutions as well?

A. Yes, I do. And again, when I talk about myself I'm talking about myself and my colleagues. We will go into a nursing home and actually write the amantadine prescriptions because it's too much of an effort for the nursing home to find all the physicians to get each one to write the prescriptions. So we predetermine with the physicians that we in an outbreak would go in and write it. And I think it's a waste of taxpayer's money to do clearances and that beforehand because you don't know when its going to occur and it doesn't help you if it was done a year ago. So we'll then at that time order tests so we

know whether or not we're overloading certain individuals. And at the point in time after that we'll then turn it back over to their physicians. In day-cares and that we go in and we write the prescriptions for the Rifampin and the various other drugs that we do have a fair amount of control over.

Q. Do you also see patients in travel clinics?

A. We run the largest travel clinic in British Columbia. We prescribe drugs for – for the people who are traveling, we give them advice, we give them immunizations. So we see one-on-one – the people that work with me do those kinds of direct care things.

Q. Is being on call part of your responsibilities?

A. The interesting thing is that that's been a bone of contention between he salaried physicians, the BCMA contract, and the Government for years. The Government will not pay for it. I felt a long time ago that I could not be on call. So I am available 24 hours/seven when I'm in town.

I have a call system with my public health inspectors who actually are paid to carry the beeper and they then have access to me through my cell phone which I keep on. My deputy, Dr. Patricia Daily [ph] has her pager on all the time because she's the major contact for the hospitals for things like rabies. Whenever there's a dog bite or whenever there's a need to make a determination on a bad bite that somebody should get treated for a bad bite she's the person that does it. I'm her back-up when she's not available to do that.

So in Vancouver we have a call schedule whereby Patricia and I are on call. The GVRD knows where to find me and I have direct calls from them. I just got one the other night again on a turbidity issue where they just want to make sure whether or not we're going to issue an advisory or whether we're going to ride out something like that. The RCMP right now have my phone. I'm their primarily contact for white powder incidents and I get involved with fire departments and that.

> Q. How many medical health officers are there in the province?
>
> A. There's 18 order in council appointed medical health officers, and there's about 10 or 12 assistants and deputies, and then a whole other group of people who probably would also be covered by this contract who work in what used to be sort of the public health area. The people that worked in the Downtown Community Health Centre and all that. That would also be people who ultimately would be benefited from this particular contract. And they're direct service physicians. They're seeing one-on-one patients on a daily basis and are paid according to that 1992 BCMS/Government document, and so are paid not all that well.

Dr. L. said he is paid $142,000 a year which he supplements by a few hundred dollars a year in honoraria related to medical matters and up to about $4,000 a year as the senior naval reserve medical advisor from which he resigned last year. He said that when he was the Chief Medical Officer for the City of Vancouver he was he highest paid MHO in Canada: now, he says, he is not in the top 25 in the country. He is now paid less than the MHO in Saskatoon, and $60,000 less that the MHO in Lethbridge, and less than the MHO's in Edmonton and Calgary. He said, "That hurts".

He also said his staff are in the same grid established some years ago without consultation, but at a salary range of from

$118,000 to $128,000, and subject to the same freeze. He related how he had sought BCMA assistance but the Government refused, saying that he and his staff were being treated as administrators.

He described various anomalies throughout the province where a MHO in the North Okanagan gets $118,000 because he does not report directly to the CEO whereas another HHO who does the same job, but reports to the CEO, is paid $126,000. He said the MHO in Williams Lake is paid less than $100,000 while the one in Abbotsford, who worked night and day on a recent meningitis outbreak started at $112,000 although he thought she had managed to get " a little bit more".

Dr. L. said he works about 50 hours a week when he is home, but he has to travel a great deal ("three trips to Ottawa in the last three weeks"), and he often works more than that when there is a botulism or anthrax outbreak.

Dr. L was asked how he became aware that the BCMA might negotiate salary scales for MHO, and he replied that he read publicity

about it and decided that, happy as he is to be a MHO, he wishes to be recognized as a doctor . He was asked what he thought of the Government's offer for salaried physicians, and he said he could not comment on it "nicely" because if all salaried physicians, like (he mentioned the thoracic surgeon) were paid the top range of the offer, $125,000, it would not even cover the extra bonuses he now gets for his highly skilled work. Dr. K's view of the Government's position was stated this way:

> Basically it – we know what's happening. The Government says: We want to save some money. We've always paid you guys badly, so we should be able to get away with continuing to pay you guys badly, and we're going to go to this arbitration and argue; A) you're not doctors, and so you shouldn't even be considered in this. And if by chance you happen to consider that we are doctors and we do things like write prescriptions and see patients and that kind of stuff, we want to make sure you continue to pay us badly…
>
> And so the offer that they put on the table says: Let's continue paying public health doctors and civil service doctors as little as possible. And let's make sure we emphasize you get about 20 percent more in benefits. So while your salary is 142 you do have to add in about 20 percent more in benefits that you get. Well, that's all well and good, but it's still well under the national average.

[In fairness, it should be mentioned that in final argument, the Government agreed MHOs should be represented by BCMA, but the

salary range remains to be determined].

In cross-examination, Dr.L said he is not treated as a member of the management team of the Vancouver/Richmond health Board, and he does not participate in the compensation plan of the other officers of that Board. He said he doesn't get "anything close to what my colleagues in the hospital are making … So if you want to look at the Vice-President, Medicine in the Vancouver Hospital, who is also a member of the management team, and look at his compensation versus my compensation, they are very different." He said that the CEO of the Board told the MHO's that they were underpaid and that they would be taken care of, but that CEO has been in office since October, 2001, and it has not happened. When asked, the CEO said that, "The time is not right." He added that the CEO is a "straight shooter".

Dr. L recognizes the Health Board is struggling with an increasing deficit, but he commented that CASK agreements, which he said were necessary to keep skilled doctors from leaving, are a part of the deficit. When asked about the concerns of other doctors

about opening up more operating rooms he said the number one goal should be to protect clinical care so the emphasis on savings should be on the non-clinical side.

When asked about funding for his programs, the doctor said his TB eradication program to get rid of tuberculosis on the Downtown East Side was cut $450,000, but cardiovascular disease and hospitalization are decreasing as is HIV, Hepatitis A, motor vehicle crashes and homicides. illicit drug deaths, which were decreasing, are starting to reverse which has cost implications. He claimed some of the credit for positive improvements in public health measures that reduce utilization demands for physicians, but he said there were multiple factors. He said;

> The Hepatitis A is definitely something that we did. We got government to fund Hepatitis A vaccine. We went to the Downtown East Side out on the street and blitzed them and gave them hepatitis A and we eliminated it on the Downtown East Side.
>
> We also got Hepatitis A for the gay population. I fought that one for almost two years. And we got it way down.
>
> …I went to my Board and said: "I can no longer give Hepatitis B. You must fund me. And they funded me. They funded me for two years before the provincial government finally got into

the hepatitis B programme. And we'll see those results within 20 years - of the infant Hepatitis program we brought in.

Dr. K agreed with counsel that the aging of the baby boom is a concern of the Health Board. It will be best to just quote his comments in this area:

Q. And I also understand from the report of the Health Board that one of the other concerns is that a lot of us are becoming to be over the age of 52, which is the baby boom age issue. And there is a concern about the amount of chronic disease that will develop in the next 20 years from the aging of those of us in our mid-50s.

A. Yes.

Q. And do you have any estimate of the impact of that aging of our -- of that group of our population?

A. The interesting thing is that what's happened with the increasing aging is that people are healthier longer. And so while we used to think a person of 65 – Bismark actually set the age of 65 for retirement not because he was a benevolent person, but because they were useless after 65. People can go well into their 80s now. The problem is that when they get sick they go like this; boom. So our care has been designed that you gradually got sick. We put you in and you were on personal care and then you were in intermediate care and then you were in extended care. That's not what happens. People go along healthy now and then boom. They have their stroke or they have their demise, they get their Alzheimer's, and they get sick very, very quickly. We're going to have to alter our method of care quite dramatically to meet the way things actually happen, not the way we imagine the things that would

always happen.

Q. Primary care is going to be reformed to be more organized and systematic and more efficient?

A. Yes. We're going to have to look at how we handle congestive heart failure, and not do it on a one-on-one basis. We know the history of what has to be done and we need to involve other people working with the physicians to – to give a better direction.

I've always said the biggest thing that we have to do is we have to do eyes, cataracts, better, we have to do hips better and we have to do knees better. These are the sorts of things that healthy older people get. And we need to be able to get their cataracts done when they need to get done, they need to get their hips and knees done when they have to get them done.

Q. And groups of specialists need to be organized better to be in centers of excellence where they can do enough volume to get better outcomes?

A. The concept of regionalization was to make those centers of excellence. If you go back to the original rural commission it talked about six regions. It talked about better aligning of various groups. … It's stupid to try and keep surgeons in Prince George by giving them more money because that still doesn't solve the basic problem. The problem Vancouver has is that we're a teaching hospital. The problem we have is that there's a critical mass of treatment that we have to do to do the teaching of the interns, your residents, your nurses and other people. You can't simply say: Well, everything is nicely – we'll just dent it back to the various regions and they'll take care of it there. It doesn't make a lot of sense. It's certainly not an efficient way to deliver it.

Q. And you'd agree that there's a challenge for the health care in transferring some responsibility for nursing practitioner to do certain routine things?

> A. I think it's – it's a logical outcome. If you think in the other vein that the majority now of graduates in 1990 – 2000 in Canada was female. Women won't be stupid and work like men did. And so you won't get the workaholics that you're gong to get. They're more attuned to going into a salaried basis for their – for their whole career. But they will not put in the enormous amounts of hours that a lot of men seem to have wanted to put in. And so we're not graduating enough doctors as it is. When you consider that half of them are females and will not put up with the nonsense that their colleagues did we're going to have to change how we did it and involve other members of the health care in a better way, absolutely.

While he was not requested to explain his statement about the "nonsense" male colleagues did, I understood from the context of his remark, particularly his previous reference to "work like men did" and "workaholics", that he was indeed equating workaholic practice to "nonsense" in the sense that many doctors do in fact work far too hard which is what I understand he was saying from my review of all of the evidence. These comments about part-time work, of course, were made in the context of doctor shortages. We all know and recognize that many highly skilled, dedicated, hard-working women physicians work just as hard as their male colleagues.

This completes the summary of the evidence of the doctors called on the arbitration by the BCMA. The government called no doctors or other evidence on clinical practice except with respect to the

consequences of withdrawals of service.